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ABSTRACT

This document provides witness testimony and prepared statements from the Congressional hearing called to investigate the cost of long-term care for the chronically ill and disabled. The merits of a public-private initiative on long-term care insurance are considered by the witnesses, who include a woman struggling to care for herself and her son, a representative from the Children of Aging Parents organization, and the coordinator of the insurance division of the American Association for Retired Persons. Statements are also presented from the director of the Columbus Home Health Services; the chairperson of the long-term care insurance task force of the American Health Care Association; and the chairman of the public policy committee, National Council on Aging. Testimony is also provided by the director of medical assistance for the North Carolina Department of Human Resources and the chairman of the Task Force on Long-Term Care Insurance, Health Insurance Association of America. The appendices contain materials on long-term care and insurance issues, submitted by witnesses, and letters and statements from individuals and organizations. (NRB)

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THE COST OF CARING FOR THE CHRONICALLY ILL: THE CASE FOR INSURANCE

HEARING

BEFORE THE

SPECIAL COMMITTEE ON AGING UNITED STATES SENATE

NINETY-EIGHTH CONGRESS

SECOND SESSION

WASHINGTON, DC

SEPTEMBER 21, 1984

CG 018230

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THE COST OF CARING FOR THE CHRONICALLY ILL: THE CASE FOR INSURANCE

FRIDAY, SEPTEMBER 21, 1984

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, DC.

The committee met pursuant to notice, at 9:10 a.m., in room 6628, Dirksen Senate Office Building, Hon. John Heinz, chairman, presiding.

Present: Senators Heinz, Warner, Glenn, Burdick, and Johnston.

Also present: John C. Rother, staff director and chief counsel; Stephen R. McConnell, deputy staff director; Diane Lifsey, minority staff director; Tricia Neuman, professional staff member; Isabelle Claxton, communications director; Roberta Lipsman, minority professional staff member; Robin L. Kropf, chief clerk; Paula Dietz, Kate Latta, and Leslie Malone, staff assistants; and Gene Cummings, printing assistant.

OPENING STATEMENT BY SENATOR JOHN HEINZ, CHAIRMAN, PRESIDING

Chairman HEINZ. Good morning. The committee will come to order.

We are here to investigate what may prove to be the single greatest threat to life savings of the American middle class, namely, the cost of long-term care. Long-term care, by which I mean the full range of services needed to support the chronically ill and disabled, has been of great concern to our committee since its inception 25 years ago.

Over the past quarter of a century, the committee has learned a great deal about long-term care. First, we have learned that many of us now in the prime of our lives will need long-term care—if we live long enough. Based on what we know today, one in every four persons age 65 and older, and three in every five persons age 85 and older need long-term care; and yet, most of us still tend to believe, "It won't happen to me."

Well, today, we will hear that it will happen to millions of us. When it does, our entire life savings, our independence, and our dignity may be severely jeopardized.

Second, the committee has learned that our American health care system is woefully ill-prepared to provide professional care to the long-term care population. There is a critical shortage of social workers, nurses, dentists, and doctors with geriatric experience and training. This shortage will only become more severe with the predictable growth of the frail elderly population.

Earlier this week, I introduced the Geriatric Manpower Act of 1984 to initiate a comprehensive, 5-year program of support for the geriatric education and training of health professionals. My bill would nearly triple the present level of commitment to manpower development in aging.

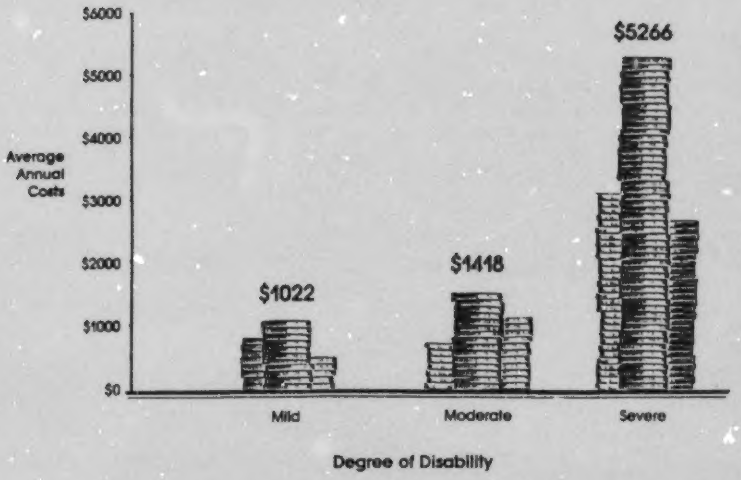
Third, we have learned that many of the people who need professional care are unable to pay for it. While most get by with the help of family and friends, others are less fortunate. Long-term care services are expensive. Insurance coverage is virtually unobtainable. Many older people and their families are forced to deplete their hard-earned savings in a very short time, to pay for needed care.

Out-of-pocket costs for long-term care services can be exorbitant. In Pennsylvania, for example, just 1 year in a nursing home for a private paying patient costs between $15,000 to $50,000. One-third of all patients nationwide who try to pay for their own nursing home care become eligible for Medicaid within just 1 year of nursing home admission. That means that, within a year, economically independent middle-income people spend down to a point where they have less than about $1,800 left to their name. Too often, the spouse of a person who needs nursing home care must decide either to spend every cent to pay their bills, or try to protect some assets. For many, this literally means a choice between poverty and divorce. That is a terrible decision for a couple to make after a lifetime together.

The cost of care at home or in the community varies, but also tends to be expensive. As you can see from chart 1, the more disabled you are, the more it will cost you to pay for your own care. Mildly disabled persons spend about $1,000 each year for care; the severely disabled spend over $5,000 each year for care. That is a considerable price to pay on top of other fixed living expenses.

CHART 1

ELDERLY OUT-OF-POCKET EXPENDITURES FOR HOME CARE



Source: 1982 National Long-Term Care Survey

Given that almost 80 percent of older families have an after tax per capita income of less than $10,000—and that includes their in-kind benefits and their annuitized savings—it is easy to see how middle class families can spend their entire life savings for long-term care in only a short period of time.

Despite the evident need for better coverage, it is virtually impossible for even the most prudent people to protect themselves against this risk. Insurance that adequately covers long-term care costs is simply not on the market. Private insurance policies generally cover very little nursing home care and even less community-based care. Medicare coverage is restricted to short-term acute and postacute care. While the Medicaid Program does provide for long-term care, it does so only for very poor people. Many older Americans find themselves caught between a rock and a hard place—they have just enough income to disqualify themselves for Medicaid, but neither the money nor the insurance to cover their long-term care bills.

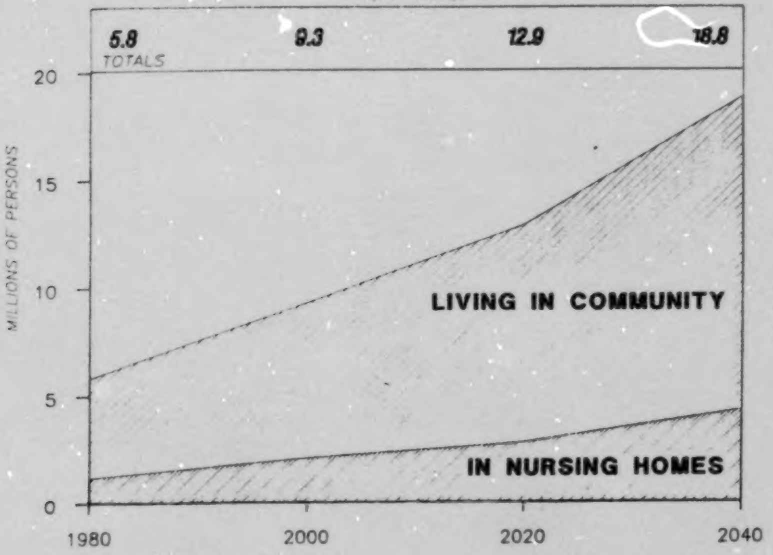
America is the land of plenty, and when it comes to insurance, by and large, it is a land of abundance. Our Nation's middle class can insure their cars against theft or damage, their houses against flood, fire, and earthquakes, their children against the costs of college and braces, and their families against the risk of an early death. But when it comes to insuring against the single greatest threat to their life savings and emotional reserves—the costs of long-term care—Americans have no protection. In many ways, it is as if we are all wearing bulletproof vests—with holes over our hearts. We are missing protection where we need it most.

And what about tomorrow? This need for insurance will become ever greater. Today, the fastest growing segment of our population, persons age 85 and older, happens to be the group most likely to need long-term care. Within a decade, this group will include another 1.5 million persons, and yet another million by the year 2000. As you can see from chart 2, the number of persons expected to need nursing home and community-based care will grow dramatically. Who is going to provide their care, and who is going to pay for it?

CHART 2

OLDER AMERICANS IN NEED OF LONG-TERM CARE

(1980–2040)



Source: 1982 National Long-Term Care Survey and 1977 National Nursing Home Survey and Social Security Administration Projections

These are some of the issues that we are here to discuss today. Each of our witnesses has been asked to consider the merits of a public-private initiative on long-term care insurance or, as I would prefer it to be called, independent living insurance. I look forward to our witnesses and hearing their testimony.

Before I call on our first witnesses, I want to call on the committee's ranking minority member, Senator John Glenn.

STATEMENT BY SENATOR JOHN GLENN

Senator GLENN. Thank you very much, Mr. Chairman.

Today's hearing covers an important issue which the members of the Senate Special Committee on Aging are struggling to resolve, and that is the financing of care for those in our society who are chronically ill.

Although a small percentage of the population under age 65 suffers from long-term disabilities, the need for care increases dramatically with age. In 1980, there were 2.6 million elderly 85 years of age or older, of whom 62 percent required long-term care services. With the number of this very vulnerable population expected to reach 5.1 million by the year 2000, just 16 years from now, we cannot afford to delay responding to the challenge of providing appropriate care.

The current cost of long-term care cannot be measured precisely. We do know that in 1983, approximately $30 billion was spent on nursing home care. Additional funds paid for a variety of noninstitutional services, including home health care, day treatment services, respite care, transportation, and meals. Various Federal and State programs cover these services for some individuals. But many services are paid for privately. Out-of-pocket costs for home care services currently range from $1,000 to $5,300 a year, as our chart shows.

In 1983, Medicaid paid about 50 percent of the bill for nursing home care. Medicare's contribution was minimal, with Medicare only paying about 2 percent of total nursing home expenditures for those over 65. And although most older people have medi-gap insurance, only a small percentage of the costs for long-term care was paid by these private policies. Patients and their families paid for a full 44 percent of the costs for nursing home care.

Coverage for less expensive, noninstitutional services is even less prevalent. In many States, Medicaid offers a variety of community and home-based programs for people with very low incomes. But for the vast majority of the elderly, neither private nor public insurance offers the financing necessary for long-term, noninstitutional care.

For those who really have not gone into some of these programs in depth, they always say, "Well, why don't the families take care of them? Why don't the sons and daughters take care of those who are having problems?" Well, I think we have developed in our society to where 20 percent of us move from one domicile to another each year. I think the last figures I saw were that 13 percent of our people move across State lines. We are now having extended families all over the country where we are no longer in the same community, growing up and staying in the same community and taking those responsibilities that previously were assumed by the families. I think that is where a national responsibility comes in, and it is the reason I have supported all these programs.

During today's hearings, we will have the opportunity to learn first-hand about the gaps in our current insurance programs. I want to thank the witnesses who have joined us today. We appreciate their willingness to share with us the difficulties they have overcome to secure services for themselves, their relatives, or others in their communities. We must use this opportunity to better understand the limitations set by Medicare, the shortcomings found in private insurance, and the biases created by a long-term care system which emphasizes institutional care.

This last point, the emphasizing of institutional care in a long-term system, is particularly important. When the Medicare Program was implemented, it was not intended to provide coverage for long-term, chronic illness, and it certainly was not intended to provide home care. The Medicaid Program adhered to this bias, and home health services were not a mandatory service under the original Medicaid Program. Only after the law was amended were States required to offer home health if they also provided Medicaid coverage for nursing home care. The home health coverage that has resulted remains very restrictive. Private insurance coverage of home health care is even more elusive. Only a few policies include coverage, and it is often restricted to the care provided by a private registered nurse.

We will be hearing from many distinguished witnesses today, and I thank each of you for your participation. I am particularly pleased to welcome Betsy Houchen from the Columbus Home Health Services. Her agency cares for over 6,000 patients per year, and the services they provide are paid for through Medicare and Medicaid, State and local assistance, private insurance, and family and charitable contributions. I live in that community and know of her work there first-hand. Her experiences will illustrate more clearly the limitations of current coverage and the need for inclusion of home-care benefits in any future long-term care insurance program.

I believe we will conclude this hearing with a better understanding of the issues involved in financing long-term care, and I look forward to hearing today's testimony.

Thank you, Mr. Chairman.

Chairman Heinz. Thank you, Senator Glenn.

I would like to call on Senator Warner now, if he has any opening statement.

Senator Warner. I think we should proceed with the witnesses, Mr. Chairman, thank you.

Chairman Heinz. Before hearing from our witnesses, I want to insert into the record, without objection, the statements of Senators Lawton Chiles and Larry Pressler, who unfortunately cannot be with use today because of prior commitments.

[The statements of Senators Chiles and Pressler follow:]

STATEMENT OF SENATOR LAWTON CHILES

The Senate Committee on Aging began taking a long hard look at long-term care issues several years ago. As a matter of fact, I recall chairing a series of hearings beginning in 1977. The intent was to produce a record that would clearly show:

(1) That the number of elderly in need of long-term care would grow so rapidly during the next few decades that the demand would rapidly outstrip any kind of care available.

(2) That the costs of an over-reliance on nursing home care could not be supported—by the elderly, their families, or by the government.

(3) That there were several alternatives worthy of Federal support; and

(4) That we had better get cracking or we would soon find ourselves in an explosive situation.

Since then, there has been some progress in developing alternatives—but I can't say that it has gone as far as I hoped it would by now.

We expanded the Medicare home health program.

We started a number of demonstrations to put different medical and social support services together in one program so we could try to meet the needs in an efficient and less costly manner.

We changed Medicaid to allows States to develop broad based programs of community care to help meet the rising demand.

All of these changes represent real progress—and they have to continue.

But I have been disturbed by the administration's slowness—and in some cases refusal—to grant Medicare and Medicaid waivers for community care programs.

I have an even stronger sense of urgency now than I did a few years ago about the long-term care crunch. During this same time period, our budget problem has also gotten worse. It is very difficult now to talk about new Federal programs to help meet mushrooming long-term care needs. It is also true that we can't ignore the situation. One way or the other, long term care needs will have to be met. The question is who is going to pay.

The Federal Government never has paid for long-term care for most elderly people in need. Not until they are very poor—when they become eligible for Medicaid. And then we pay about one-half of the cost, and the States have to deal with the rest.

Even so, many elderly who enter nursing homes eventually do become poor enough to get some Medicaid help. Almost one-third who enter nursing homes as private-pay patients become eligible for Medicaid within 1 year.

So even if we don't commit a lot of new resources to finance long-term care, we still will have a growing Medicaid bill just for nursing home care. It will be $60 billion by 1990.

There will always be a Federal role. And we will continue to seek ways to shape and change our Federal health programs to meet the chronic care needs of the elderly and others.

This hearing will begin to explore one of the more recent developments in the area of financing long-term care. The concept of broader private health insurance coverage for long-term care is still young, but it is time to take a look at its possibilities. At the very least—if there is a way that a younger generation might have a better opportunity to plan ahead and purchase some protection against financial ruin from a long-term chronic illness—we need to begin exploring the issues now.

STATEMENT OF SENATOR LARRY PRESSLER

Mr. Chairman, I would like to thank you for bringing together this morning's hearing. It is most important for Members of this Congress to look at the question of the cost of caring for the chronically ill.

It is startling to learn that in the coming year, an estimated 6.6 million Americans age 65 and over will need long-term care. This means that one out of every four senior citizens in this country will face the staggering financial risk that the need for such care brings about.

It is unfortunate that many people have mistaken ideas about the avenues they can pursue in paying for such care. Medicare was designed to cover short-term acute and post-acute care—not long-term care. Nursng home care is only covered for 100 days. The first 20 days are completely covered, and for the remaining 80 days there is a daily copayment which is currently $44.50 per day. Medicare therefore covers less than 2 percent of the total national nursing home expenditures.

Two out of every three older Americans do purchase medical insurance policies, but these policies are designed only to supplement Medicare's coverage. It therefore becomes the responsibility of the Medicaid program to be the primary source of public funds for long-term care. As elected representatives, it is our obligation to evaluate payment options available to us.

I look forward to the testimony of the fine witnesses we have with us today. They can help us responsibly answer the question: How do we pay for the long-term care that one out of four Americans will need?

Chairman **Heinz**. I am very pleased that we do have such a distinguished list of witnesses. Our first two witnesses are both Pennsylvanians—just coincidence. We are delighted that Ella Thomas and Mary Kinslow are here; also, another panelist, Ron Hagen.

Mrs. Thomas, would you be willing to be our first witness, please?

Mrs. **THOMAS**. Yes, sir.

Chairman **HEINZ**. We want to welcome you to the committee, and I want to thank you for coming all the way down here from Philadelphia; we are most appreciative.

STATEMENT OF ELLA THOMAS, ACCOMPANIED BY BRENDA RASCHER, SOCIAL WORKER, PHILADELPHIA, PA

Mrs. **THOMAS**. Thank you.

My name is Ella Thomas. I would like to read my statement to this committee myself, but because of poor eyesight, that is not easy for me to do. Therefore, I have asked Brenda, my social worker, to read my statement for me. But first, I would like to say a few things to you myself.

My husband and I had always been able to take care of ourselves and our son, Raymond, who is mentally retarded. We never had to ask for any help from anyone. But when I had my stroke 3 years ago, everything changed. It all happened so fast that we did not know what to do.

We jumped at the first thing we found, so I could stay at home. We spent all of our life savings in 3 years, about $66,000. When I think of all that money, I get so upset. It is awful.

I was told to go to a nursing home, but I do not want to go to a nursing home. I want to stay home with my son, in our home. Now that my husband is dead, I am responsible for my son. I have to care for him.

I know some people say that I cannot do anything for myself, but I can. The most important thing is that I can make my own decisions, and think for myself.

I want you to know that my being here proves how important this is to me, for this is basically the first time I have been out of my house in nearly 3 years.

Thank you.

Chairman **HEINZ**. Mrs. Thomas, thank you. You have been housebound for 3 years, and for you to make the effort to come down here is extraordinary. To me, it shows how much you really mean it when you say you want to continue to make your own decisions, that you want to continue to be proud and independent, and try as best you can to make your own life and take care of your family responsibilities.

I understand that Ms. Rascher is going to read the rest of your statement; is that correct?

Mrs. **THOMAS**. Yes.

Chairman **HEINZ**. Ms. Rascher, would you please proceed?

Ms. **RASCHER** [reading]:

Prior to 1981, both my husband and I were in very good health. We had always worked and saved all of our lives while we cared for our handicapped son. My husband retired as a leather worker when he turned 65, and I retired 2 years later from my job at a movie theater. Along with our son, we had planned to use our savings to go on trips and to fix up our house. We had also planned to set aside some money for our son's care after we were gone.

We were doing everything we wanted until October 16, 1981, when I had a stroke, and all of our plans were forced to change. I spent the next 6 months in and out of four different hospitals and rehabilitation centers. Despite the therapy I received, I was unable to totally recover and required a lot of care. I was discharged to go home and to be cared for by my husband, who was then 78 years old. My husband did everything around the house and helped my son and I with all of our care. However, the demands on him were too great.

After 1 month, he had a stroke. While he was in the hospital, my nieces cared for me, but they worked fulltime and had responsibilities to their families, too. In an attempt to get more help, we contacted an agency advertised in a local newspaper that offered 24-hour assistance with personal care and household tasks. It was the first thing we found.

Using the combination of our savings and our monthly income, we paid approximately $458 per week for 24-hour homemaker services. We continued this service after my husband returned home for, although he recovered to the point where he could care for himself independently, he was unable to assist with my care.

While the homemaker service provided for my personal care and meals, two of my nieces did all of the money management, shopping, errands, and household maintenance. We never changed it, because we were afraid to lose the help, and we did not know any other way to do it.

As a result, we spent our entire savings along with most of our monthly income in just 3 years. The 3-year bill totals $66,000. If I had known how to do things differently, I would never have spent all of my money that way. It is overwhelming to me to think of how I wasted my life's savings. Yet, the only alternative I was given was to go into a nursing home. No one ever informed me of any other way.

I do not want to go into a nursing home. My main reason is my son, Raymond. My husband and I had always cared for him, and now that my husband is dead, the responsibility is mine. I just wish I had known how to use my money differently, so my son and I would still have some of it left.

I would like to thank this Senate Committee for the opportunity to tell my story, and I hope that others may benefit from what happened to me.

Chairman Heinz. Mrs. Thomas, your story touches the hearts of everybody on this committee and everybody who hears it, and I have some questions for you and Ms. Rascher that I will direct in a moment. Before doing that, I want to ask our next two witnesses to make their statements, and then I will return to you.

Ms. Kinslow, you are a member of the board of directors of Children of Aging Parents, in Levittown, PA.

Ms. Kinslow. That is right.

Chairman Heinz. We welcome you, we thank you for what you are doing, and we are especially appreciative of your coming down here to testify before our committee.

Please proceed.

STATEMENT OF MARY KINSLOW, FOUNDING MEMBER, CHILDREN OF AGING PARENTS, LEVITTOWN, PA

Ms. Kinslow. Thank you very much, Senator Heinz, I would like to thank you and the committee for the opportunity to speak to you today on the problems and concerns of family caregivers.

I am here on behalf of an organization called Children of Aging Parents, or CAPS, for short. CAPS is a nonprofit, self-help peer group organization, dedicated to serving the needs of family caregivers who, like myself, are struggling to provide the needed care to their aging parents.

CAPS began very informally 7 years ago. Three women from Levittown, PA met in a neighbor's living room to talk about how they could care for their elderly parents and to get some idea of the services available in their community. Shortly after their first meeting, one of the ladies sent a letter to "Dear Abby" which described the informal CAPS meeting and the problems of being a family caregiver.

Senator, the response to that letter was astonishing and overwhelming. I never dreamed that there would be so many other children in this country with our same problems. And when I say "children," I mean adults in their fifties and sixties who are themselves looking forward to retirement and who are looking forward to spending more time with their own children and grandchildren.

Today, there are over 10,000 members of CAPS, and the number is growing larger every day.

I brought with me today just a few of the letters I have received from family caregivers, describing their frustration and heartache. I would be happy to share them with the committee.

Their stories are not unique, nor are they unusual. I can tell you about many, many other family caregivers who are experiencing the same pain and frustration in caring for their chronically ill parents. As a social worker in a nursing home, I have seen the tired and confused look of sons and daughters who no longer recognize their once active, vital parents. These children are not prepared to care for the needs of their aged parents. They are not prepared for the tremendous financial drain on their lives. And they are not prepared for the emotional and physical strain that they alone will face in caring for their aging parents.

Senator Heinz, I have seen families separate because of these burdens. I have seen the anger and pain on the faces of teenage children because their chronically ill grandmother or grandfather is living with them, and their home has changed so drastically. I have seen the hate, guilt, and anger exchanged between parent and child where there was once love, admiration, and respect.

These are not hateful people, Senator. They are proud and loving families who do not understand the drastic changes in their lives and who are not prepared to cope with the overwhelming responsibility of caring for their parents.

Most family caregivers simply cannot afford to provide the kind of long-term care that their parents require. I was very fortunate that, given my financial resources, my background in social work, and the nature of my mother's handicap, I was able to establish an adult day care center connected to my own home, where I can provide the kind of care my mother requires.

But the majority of family caregivers have very few options. There is very little reason for hope. Most of the families I have counseled do not want what they call welfare. These are proud people who want to find their own way, and they often do—but at a tremendous emotional and financial cost to their own lives.

A daughter who was caring for her father—he had suffered a stroke 3 years ago—told me how much she loved her Dad. "I know it is a chore," she said, "but when he smiles, it makes things right." She told me she pays $12 an hour for a home health aide so that she can go out on a date. And she said, "At those prices, he darn well be a good date." With a tear in her eye, she told me she guessed she would never get married.

Please do not get the wrong idea, Senator Heinz. We are not asking for your pity. No, we are just crying out for some help, for a better way to help family caregivers as we struggle to care for our mothers and fathers. Family caregivers are trying to do the best they can, but the burden is just too great for most.

I do not want to be a burden to my son. I know the fears and frustrations that I have felt in caring for my own mother, and I do not want that for my son. I love him too much But, Senator, if I could prepare for the future, if I could prepare for the care that I will need someday, and spare my son this agony, there is no doubt that I would.

Please, Senator Heinz, we need your help desperately.

Thank you. I would be glad to answer any questions you might have.

Chairman HEINZ. Ms. Kinslow, thank you. I will have, as I imagine the members of the committee will have, numerous questions for you. What you are doing is unusual. You have the ability, as you say, to be a little bit more fortunate in taking care of your parent and having established your own adult day care center. I would like to ask you, when the time comes, about people who are a lot less fortunate than you, whom you know, and with whom you have some personal experience.

Before I do that, I want to call on the last member of this panel, Ron Hagen, the coordinator of the insurance division for the American Association for Retired Persons.

Mr. Hagen?

STATEMENT OF RON HAGEN, WASHINGTON, DC, COORDINATOR, INSURANCE DIVISION, AMERICAN ASSOCIATION OF RETIRED PERSONS

Mr. HAGEN. Thank you, Mr. Chairman and members of the committee. I am indeed pleased to be here this morning to discuss a subject with you of great and continuing importance to our association and the many millions of members of our association, the delivery and financing of long-term care services for the chronically ill.

Our association has frequently testified before this committee and elsewhere, that the lack of a comprehensive long-term care system that encompasses medical, social, and personal care services provided in a variety of community, home-based, and institutional settings is the greatest deficiency in our present health care delivery system. Indeed, our growing aged population, increasing life expectancy, increased instance of chronic disease and illness and changing family patterns, there is greater pressure than ever to search out private financing mechanisms to meet the very substantial and rapidly escalating costs associated with the delivery of long-term care services.

This year alone, estimates are that the elderly will spend approximately $868 per capita on nursing home care, of which $450, or almost 52 percent, will be spent out-of-pocket. This is more than double what was spent by the same group in 1977.

Long-term care insurance is being increasingly mentioned and is playing an important role in financing such services, yet I must tell you up front that the promise that meaningful, private long-term care insurance holds at this point is still just that— a promise. The interest and optimism surrounding the prospect of developing truly meaningful long-term care insurance appears to be well ahead of the insurance industry's current ability or inclination to develop such coverages which provide realistic and predictable benefits at a reasonable cost.

To state the obvious, it is in part because of the success of Medicare and private health insurance that people are living longer and in turn are subject to higher frequencies of chronic illness and disease, thus generating the need for more extensive long-term care services and a great deal of interest in private long-term care insurance.

To put this subject in perspective, I would like to share with you the results of research our association commissioned earlier this year. There are many avenues for private sector involvement in long-term care. For our association, private insurance meets some of the costs associated with long-term care, but is but one of these avenues.

As part of a process our association has undertaken to better understand our members' needs and preferences, concerning the continuum of long-term care services and the financing of these services, we commissioned the Gallup organization late in 1983 to do a survey of our membership. We were interested in the feasibility of the association developing its own insurance program to cover long-term care, but we also wanted to get a handle on the perceived needs of our membership for private insurance, our members' utilization currently of long-term nursing home and home health care services, as well as their expectations and attitudes about nursing home and home health care services.

The major findings of our survey were as follows. There was an overwhelming preference for home care versus nursing home care. There were relatively low utilization of nursing home as well as home health care services. There was widespread concern among our members about not having enough money to pay for extended nursing home and home health care services. There was great confusion—and I would emphasize, great confusion—about what Medicare and private insurance pays for and what they do not pay for. There was significant interest in learning more about long-term care insurance, and there were very unrealistic expectations about the price of nursing home insurance.

We also found two groups that resulted from this survey that were very much interested in the area of long-term care insurance. One term we will term the "indirectly aware group" and was about 41 percent of the respondents and were individuals who had, either through a relative or a friend, some direct experience with an individual who had been in an institution for an extended period of time and had considerable costs associated with that. The other group among our membership that was most interested in private long-term care insurance was the younger segment of our membership, the under-65 portion.

We also found that many of our members, in preferring home health care to nursing home care, felt that it would be very difficult to find a place in a nursing home that provides satisfactory care.

Somewhat surprisingly, though, over one-quarter of all of our members who responded to this survey believed that they would, in fact, need to be in a nursing home for more than a month at some point during their lifetime.

But most troubling of all—and for which we have a chart at the side of the room—there was a very clear indication, as you can see from chart 3, that most of the individuals, 79 percent in all, felt that Medicare would pay for some portion of their expenses. There was also a feeling that private savings and private insurance, both group and individual, would pay for a significant portion of the expenses associated with long-term care. This reflects a great deal of misinformation and misunderstanding as to what Medicare and private health insurance currently pay for relative to long-term care. It suggests, in fact, that the respondents to our survey are either unaware that they lack long-term care coverage, or else they do not perceive it as a deficiency.

CHART 3

HOW WOULD YOU FINANCE A NURSING HOME STAY?

	Percent
Medicare	79
Earnings/Savings	53
Private Insurance	50
Medicaid	17
Children	10
Relatives	2
Other	9
Don't Know	1

Total: 221%

*Exceeds 100% due to multiple responses

Source: AARP/Gallup Long-Term Care Survey

Undeniably, many risks exist in developing private insurance for long-term care. Hand-in-hand with this, however, goes the need to better educate and inform the public about such insurance coverage and more particularly, the limitations of our public and private insurance programs.

Older Americans today face a myriad of choices and conflicting claims in the private health insurance marketplace. Coverages are widely misunderstood, and purchasing decisions frequently made with totally inadequate information. It is important, therefore, that in developing long-term care insurance, we work with state and Federal regulators to require adequate disclosure through such mechanisms as outlines of coverage and buyers' guides, similar to those currently required in the sale of medi-gap insurance.

But again, private long-term care insurance is not the answer. Other forms of equity conversion and private financing must also be explored. This could include such approaches as reverse annuity mortgages, sale-leaseback arrangements, or even IRA's for long-term care.

In seriously approaching this subject, we must all realize that in essence, what we are proposing here is a cost shift of sorts where, instead of the general population through the Medicaid Program meeting a substantial part of the long-term care costs associated with this age group, we are saying that older Americans themselves will be asked to pool their resources and in essence spread the risk by meeting a significant portion of these expenses through some kind of private insurance or equity conversion scheme.

To conclude, then, many of our members have clearly indicated to us a need and a desire for some form of long-term care insurance. In contrast to the recently released HIAA task force report on Long-Term Care Insurance, which states that, "As long as Medicaid exists in its present form, there would be no demand for private long-term care insurance," the AARP Gallup survey shows that the vast majority of elderly persons do not view Medicaid as an acceptable alternative. Medicaid is seen at best as an insurer of last resort, to be avoided if at all possible. Our survey also clearly indicated that improvements in our public insurance programs and cooperative public-private sector initiatives in educating and informing the elderly about long-term care are of great importance. Innovative regulatory philosophies are also essential if the private sector is going to successfully meet a greater proportion of the increasingly substantial costs associated with long-term care.

In sum, private insurance has an important role to play, but realistically, it is not our salvation—merely a piece of the long-term care financing puzzle.

Thank you, Senator. I appreciate being here today.

Senator HEINZ. Thank you very much, Mr. Hagen. Your prepared statement will be inserted into the record at this time.

[The prepared statement of Mr. Hagen follows:]

PREPARED STATEMENT OF RON HAGEN

I am pleased to have this opportunity to discuss with you today the problems inherent in expanding private insurance coverage for long-term care services. From the elderly's point of view, the lack of a comprehensive long-term care system that encompasses medical, social, and personal care services provided in a variety of community, home based, and institutional settings, is the greatest deficiency in the present health care delivery system. Moreover, for all the demographic reasons you have heard time and time again: A growing aged population, increasing life expectancy, chronic disease as the dominant pattern of illness in the United States, and changing family patterns; long-term care insurance appears to have an important role in financing necessary services. The optimism surrounding the prospect of private long-term care insurance appears to be many steps ahead of the industry's current ability to develop an insurance policy that provides realistic and reliable benefits at a reasonable cost. So I must tell you up front that the promise of private long-term care insurance is, at this point, still just that—a promise. Having said that, it is useful for us to understand the obstacles to establishing such coverage so that we can address them and hopefully foster the development of meaningful long-term care insurance coverages.

Before taking up what I see as the major problems hampering the development of coverage, it is important to remind ourselves that long-term care insurance will never be the solution to financing long-term care services. It is but one of many initiatives that must be undertaken to address long-term care needs of our people. To better define the range of initiatives I am suggesting, permit me to state AARP's policies regarding public and private sector roles in long-term care:

(1) A long-term care program must be developed which provides a complete continuum of care and creates in the process a network of community-based centers that would function as providers, payors, certifiers, and evaluators of services.

(2) Because family members now provide approximately 80 percent of the elderly's long-term care services, it is important to recognize family members as caregivers and to sustain—not supplant—family care activities.

(3) AARP strongly supports the Medicaid waiver provisions approved as a portion of the 1981 Omnibus Reconciliation Act which allows States utilizing this waiver to provide a wider range of community and home based services such as personal care services, adult day care, and respite services in lieu of nursing home care.

(4) AARP supports the use and expansion of the ACTION Senior Companion Program which provides low-income older people with the opportunity to support and assist their peers who, without the aid of a Senior Companion, would probably be institutionalized.

(5) AARP believes that a comprehensive prenursing home admission screening and assessment program for potential nursing home residents should be developed.

(6) AARP urges greater research into the social HMO (SHMO) concept in which a single provider entity assumes the responsibility for acute inpatient, ambulatory, rehabilitative, extended care, home health, and personal care services under a prospectively determined fixed budget; and

(7) AARP urges private sector involvement in the area of long-term care, for total reliance on either sector to solve the crises that exist in providing and financing chronic, long-term care services cannot be successful.

There are many avenues for private sector involvement in long-term care; private insurance assisting with the costs of long-term care is one of these avenues. In an effort to understand our members' needs and preferences concerning insurance for long-term nursing home and home health services, AARP commissioned a survey by the Gallup organization in 1983.

The survey revealed that the vast majority of individuals, when asked who will pay for their long-term care, indicated that Medicare would be the primary payor, with private savings and private insurance (both group and individual) being secondary sources. This reflects a great deal of misinformation and misunderstanding as to what Medicare and private insurance currently pay for relative to long-term care.

Almost half (47 percent) of the respondents stated that they would be interested in learning more about insurance that covers long-term nursing home stays. This interest was especially high among the under-65 respondents and among those respondents who have recently had friends or relatives in nursing homes; this latter group we've termed the "indirectly aware." Respondents who were interested in learning more about extended nursing home coverage, however, had widely varying expectations about price. Most of those surveyed had no idea about how much they were willing to pay.

The interest of our membership influenced AARP to explore the possibility of offering a long-term care insurance product as part of our group health insurance program. AARP and insurance industry consultants have worked extensively during the past year to develop a long-term care insurance policy that will cover intermediate and custodial care, as well as meaningful home care benefits.

There are very real problems in the development of the policy itself. For example, research is undoubtedly needed focusing on such areas as market demand, risk analysis, marketing, distribution, and mechanisms for limiting open-ended liability. Also, criteria need to be develop to distinguish between SNF, ICF, ICF/MR, and custodial care. The almost total absence of reliable data on induced as well as planned utilization and claim cost experience is a major obstacle to pricing long-term care coverage.

There are many questions that must be addressed when developing long-term care insurance: How should a program limit adverse selection? Should there be "open enrollment," and if not, what restrictions should apply to underwriting this coverage? Should long-term care insurance be on an indemnity, as opposed to expense-incurred basis? For example, paying for institutional or home care at a rate per day of confinement, rather than as the basis of expenses incurred? Another important question is whether long-term care insurance should be part of a general life or annuity product, or whether it is preferable that it be stand-along coverage. Could a conversion option be built into a life insurance product providing a long-term care insurance option at some crossover point?

How should premium pricing be established in the absence of adequate price, cost and utilization information? State regulations on reserves needed to pay claims must also be addressed. It is likely that a newly developed long-term care policy will initially have relatively low loss ratios. But, given the volatility of such a product and the lack of adequate information on which to base pricing decisions, long-term claim payouts will likely represent a relatively higher percentage of premiums paid. Yet this is unpredictable at best, and only as loss ratios and experience is acquired will we know the wisdom of previous pricing and reserve decisions. Therefore, mandating minimum loss ratios for such a product would be unwise; indeed, preferential tax treatment of reserves may be necessary during the developmental stage of long-term care insurance coverage. The issue of taxation of reserves is important because interest income on reserves accumulated in the early years of such a policy will undoubtedly be necessary to pay claims in the latter years, as the loss ratio on long-term care coverage matures.

In designing a long-term care product, it should be acknowledged that the financial structure of a long-term care policy is very similar to a moderate amount of individual whole life insurance. However, State and Federal regulating authorities will likely not require that cash values be awarded to terminating individuals. Out of concern for equity, a long-term care policy should consider providing cash values in the event the long-term care benefit is not "fully" used. This would avoid the problem of someone's paying $40 to $50 per month for 10 or 15 years without receiving any benefit at all. The policy should state that a percentage of the premium would be returned to a designated beneficiary in the event of the death of the policyholder during a specified period. Such a benefit, however, would increase the amount of the premium.

Another area of concern in designing private long-term care insurance is mandated benefit legislation. Several State legislatures now have before them such legislation aimed at forcing insurers to offer such coverage. By mandating that certain benefits must be available—for example, intermediate or custodial nursing home care, the State is running the risk of pricing those most in need of the coverage "out of the marketplace." Thus, legislation such as that introduced in New Jersey or Kentucky is in our view counterproductive, because it would force most, if not all, companies out of the long-term care insurance market and stifle innovative "risk takers" otherwise willing to write this coverage. Other problems with mandated benefit legislation include: (1) The absence of an informed, consuming public able to draw distinctions among long-term care policies or between real long-term care insurance and other, more limited and commonplace coverages; (2) little in the way of protection for the consumer against insurance fraud, particularly overinsurance and duplicative coverage; and (3) possible stifling of innovative service delivery/insurance mechanisms as social health maintenance organizations (SHMO's).

In addition to considerations of the type of benefits that should be provided in such a policy, there are certain underwriting considerations that must be taken into account. As part of our association's group health insurance program, efforts are underway to develop such a product. In this regard, we have had to accept some rather unpalatable, yet necessary restrictions. First, open enrollment, community rated, expense-incurred long-term care coverage is unrealistic.[1] We will probably need to underwrite such coverage via a short-form "medical" questionnaire. For the first time we would be rejecting some of our members who wanted to participate in our association's group health insurance program.

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[1] An indemnity benefit providing inflation protection seems more realistic.

Further, the very substantial risk involved in insuring this age group against chronic conditions must be addressed. Adverse selection must be limited. Therefore, it is likely that any policy we were to offer would at first require elimination periods, deductibles, preexisting conditions exclusions, and perhaps a more narrowly defined benefit package than we would otherwise like.

Also, while we are intent upon making home health care an integral part of our policy, defining this noninstitutional benefit without further inducing demand for the service is truly a "wild card." With such little data upon which to base pricing decisions, adding the uncertainty of of meaningful home care coverage significantly complicates developing an affordable, attractive, and marketable plan for our members.

As you can see, many risks exist in the private insurance area. There is an undeniable need for data and research. Systematic as well as joint public/private sector efforts must be initiated to collect cost, price, and utilization data. Length of stay information as well as data on diagnoses, discharge history, level of care, and "limitations-in-activities-of-daily-living" are other areas that must be fully defined in order to assess risk and the insurability of the continuum of long-term care services.

Notwithstanding the technical difficulties of underwriting long-term care coverage, there is also the need to educate the public about such an insurance policy, and more particularly, the limitations of group and individual long-term care coverage.

Today, older Americans face a myriad of choices and conflicting claims in the private health insurance marketplace. Coverages are widely misunderstood and purchasing decisions frequently made with wholly inadequate information. Whether it is a medi-gap policy, a nursing home indemnity plan for skilled nursing care, or a major medical plan, many older Americans buy policies that purport to fill Medicare's or their group insurance "gaps." It is essential in developing long-term care insurance, therefore, to require complete disclosure through a specific outline of coverage stating what is and what is not covered by the policy. Policy limitations, exclusions, and definitions must fully address the maximum benefit duration, deductible period, the amount of benefits, limitations on benefits, and whether the benefits apply to skilled, intermediate, or custodial nursing home care.

Legislation similar to the "Baucus Amendment," requiring that policies advertised and sold as Medicare supplement plans meet certain minimum standards is needed for long-term care policies to protect potential buyers. Moreover, it is essential that all State insurance departments police the marketing of private long-term care insurance (and medi-gap insurance policies) to prevent abusive practices, frauds, and misrepresentation. It is particularly important that State regulators make every effort to assure policy comparability without specifically mandating benefits. Since the vast majority of policies restrict coverage to skilled care in a nursing home, the fact that custodial or personal care is not a benefit should be clearly and directly stated to avoid agent or direct mail offers implying otherwise. Much like "medi-gap" policies, the sale of long-term care insurance needs to be examined and claim payment practices carefully monitored to prevent the elderly from purchasing unnecessary policies.

Should the private insurance marketplace truly develop meaningful long-term care insurance options, it will also be the collective responsibility of public service organizations, like AARP who work closely with State regulators to help consumers make informed decisions.

In conclusion, as cited in the results of the AARP/Gallup long-term care research survey, the elderly both need and desire some form of long-term care insurance. In contrast to recently released HIAA task force report, "Long-Term Care Insurance" stating that "as long as Medicaid existed in its present form, there would be no demand for private long-term care insurance," the AARP/Gallup survey shows that the vast majority of elderly persons do not view Medicaid as an acceptable alternative for meeting their long-term care needs. Medicaid is seen by most elderly as the "insurer of last resort," to be avoided if at all possible.

Again, it must be remembered that private insurance is only part of the answer to our long-term care financing dilemma. Improvements in our public insurance programs, and cooperative private/public sector initiatives in educating and informing people about long-term care are of equal, if not greater importance. Innovative regulatory philosophies are also essential if such equity conversion schemes as reverse annuity mortgages, sale/lease back arrangements, and IRA's for long-term care are to work. In sum, private insurance has an important role to play but realistically, it is not our salvation but merely one piece of the long-term care financing puzzle.

Chairman HEINZ. Thank you very much, Mr. Hagen.

Mrs. Thomas, let me ask you, did you or your husband ever think that what has happened to you—in terms of depleting your savings and not having any help when you confronted an unexpected illness—did you ever think that what eventually happened to you would happen to you?

Mrs. THOMAS. No, sir.

Chairman HEINZ. You had no idea that things would happen like this.

Mrs. THOMAS. No. That is right.

Chairman HEINZ. Now, you mentioned, I think that you are covered by Medicare and Blue Cross insurance.

Mrs. THOMAS. Yes, Senator.

Chairman HEINZ. And you have obviously had very heavy expenses, $66,000 worth in the last 3 years.

Mrs. THOMAS. Yes.

Chairman HEINZ. Did Medicare cover any of your costs?

Mrs. THOMAS. No, sir.

Chairman HEINZ. Did Blue Cross cover any of your costs?

Mrs. THOMAS. No, sir.

Chairman HEINZ. None at all?

Mrs. THOMAS. None at all.

Chairman HEINZ. Are you eligible for Medicaid, since you have spent so much of your money?

Mrs. THOMAS. No, sir.

Chairman HEINZ. And that is because your Social Security is, what, about $6,000 a year?

Mrs. THOMAS. No, sir. Between my son and I, my boy at home, I get about $1,000 a year; I get $500 for me, and about $400 for Raymond for 1 whole year.

Ms. RASCHER. That is for 1 month.

Mrs. THOMAS. Per month. That is right, that is right. I am sorry.

Chairman HEINZ. As you mentioned, you make your own decisions.

Mrs. THOMAS. Yes.

Chairman HEINZ. You mentioned that you would not want to consider entering a nursing home.

Mrs. THOMAS. No, Senator.

Chairman HEINZ. Why is that?

Mrs. THOMAS. Well, I have responsibilities to my son. And I may not have many more days on this Earth, but I want to spend them with him.

Chairman HEINZ. That is your son, Raymond?

Mrs. Thomas. That is my son, Raymond, who is retarded.

Chairman HEINZ. Is he able to help you around the house at all?

Mrs. THOMAS. Well, he puts the garbage out, and he locks the door, and he does little things like that, but he cannot do anything heavy.

Chairman HEINZ. But he does help you.

Mrs. THOMAS. Yes, he does.

Chairman HEINZ. And do you help Raymond?

Mrs. Thomas. Yes, sir. I am responsible for him. I make his decisions—when he goes to the center, which he does about three times a week, I make sure he is neatly dressed; I instruct him to do things right for me.

Chairman Heinz. Let me ask Brenda one or two questions.

Brenda, in her testimony, Mrs. Thomas said that her husband was with her for about 2 years after her stroke. Did he provide any of Mrs. Thomas' care?

Ms. Rascher. He was unable to provide actual hands-on personal care. He was able to still help manage the money, do little things around the house, but they had to have a homemaker in order to do the actual care.

Chairman Heinz. In your experience, is that a fairly usual situation?

Ms. Rascher. Yes, very much so. A husband or a wife gets to the point where they cannot physically do it, but have no intention of separating.

Chairman Heinz. Could you explain to the committee why Medicaid would pay for Mrs. Thomas' nursing home care, even though she has chosen not to seek nursing home care, but it will not pay for her home-based care, care in the community?

Ms. Rascher. OK. It will not pay for the home-based care because of the fact that her income is too high. She gets about $500 per month in Social Security. That automatically excludes her from eligibility for medical assistance. However, if she were to go into a nursing home, they would subtract her $500 from the amount of the nursing home, and then the medical assistance would be the supplement, would pay for the remainder of the amount. And her house would then have a lien put on it, so when it was sold, the money would go toward the nursing home care.

Chairman Heinz. And the net result of that is that she could go to a nursing home, which would be costly for her, something she does not want to do—and it would be costly in part to the taxpayers, because it is financed by the Federal and State governments; it would obviously take her Social Security and her independence, and clearly, she does not want to lose that. On the other hand, Medicare will not pay a much lower cost, namely, that of community-based home care services, so that she does not have to make that choice, and the taxpayers do not have to be hit with that additional bill.

Ms. Rascher. Yes sir; as well as the fact that the State would then become responsible for her son, who she can now keep home.

Chairman Heinz. Would you say Mrs. Thomas' case is unusual?

Ms. Rascher. No, it is not.

Chairman Heinz. Mrs. Thomas, I am afraid there are many people like you who have the same kinds of terrible choices, and you have done us a great favor in explaining those choices to us in a way I do not think we are going to forget.

I might mention for the benefit of the committee that Mrs. Thomas is indeed a bit more fortunate than most people in her case because we have a Channelling Demonstration Project in Philadelphia, which I think is why Brenda Rascher is indeed available to assist her. That is only a demonstration project. It does not exist in most other parts of the country. And so we might ask ourselves the question, if Mrs. Thomas has had very terrible choices to make with that help, what is it like for everybody else who do not have that help?

Mrs. THOMAS. You see, Senator, Catholic Charities advised us to go to this. We did not know about them at the time, and we could have saved ourselves a lot of money if we had known about this at first.

Chairman HEINZ. My time for questioning has expired. We are running on a 5-minute rule today, John. I want to yield to my colleague, Senator Glenn.

Senator GLENN. Thank you, Mr. Chairman.

I would like to ask Ms. Rascher, how much of this is due to people not having information available to them? As Mrs. Thomas has said, she did not know some of these other things were available. Is information flow part of the major problem, or is it just flat funding once you get the information?

Ms. RASCHER. Yes, Senator, I think it is very much a major problem. Most of the people like Mrs. Thomas have, as she said, taken care of themselves all their lives and never needed to look to an agency, and have been very afraid, in fact, to go to an agency for help, because it seems like they are now no longer capable.

If she had at least had someone who would sit down with her and her husband and budget, and make out a plan in which they would not have had to spend that much money—just given information about what else is out there.

Senator GLENN. In your experience, the people who come in to help, people that Mrs. Thomas testified they spent so much money on through the years, the people they read about in an ad in the paper—is it a legitimate and good function these people are performing, or is this a scalping operation that preys on those who are already in deep trouble?

Ms. RASCHER. It is both legitimate and a potential preying on someone who is already in trouble. The services that she got are very much needed. She would not have been able to stay home without those services. If she had had someone to work with her and plan a little better, she would not have used 24-hour services, because there were other resources, family, and her finances to work it differently. However, there was no one to tell her that.

Senator GLENN. Do you get involved in an outreach program to help people like this in your work, or do you just respond when there is a final call for help, when all else has failed?

Ms. RASCHER. We would like to get them before all else has failed, because then we have more to work with. If we had gotten Mrs. Thomas 2 or 3 years ago, it would have been much different, very much different.

Senator GLENN. Thank you.

Ms. Kinslow, you say you have set up an adult day care program.

Ms. KINSLOW. Yes, sir.

Senator GLENN. And could you tell us more about this? Are you licensed? Do you have to have a license to do this? Do you receive any Government funds? How many people attend? What is the success rate of this?

Can you tell us a little more about your experience?

Ms. KINSLOW. My adult day care center is licensed. It was primarily set up to care for those seniors who cannot adequately care for themselves.

Senator GLENN. Do they have to be licensed?

Ms. KINSLOW. So many people have applied for licenses, that apparently, they have not been able to get them at this time. And because the need is so great, they have opened facilities without licenses.

Senator GLENN. Go ahead. I am sorry to interrupt you.

Ms. KINSLOW. There are two forms of adult day care. There is social day care and there is medical day care. Partial coverage can be found under Medicare for medical day care, if notations are such that they are benefiting from attending a medical day care center. A social day care center, at this time, there is very little funding for this. It is more of a maintaining of social skills, mental skills and faculties that they now have. It is of proven success to the caregiver and to the elderly person. It is a wonderful, innovative way to really care for the elderly today.

Senator GLENN. Do the people coming to the center pay anything to you for this, or is this all by other funding?

Ms. KINSLOW. Yes, they do. Prices do vary. My prices are $2.50 an hour for my full-time guests, which is phenomenal in this day and age. Other agencies and centers charge as high as $15 to $18 an hour.

Senator GLENN. How many people do you handle at the center?

Ms. KINSLOW. I have a total enrollment of 22 people. We have full-time people who attend 5 days a week; we have people who attend 3 days a week, and some only in the afternoon, depending on their physical condition.

Senator GLENN. Mr. Hagen, in your survey were you able to do any cross-tabulations in relation to the 25 percent of the people who felt they would need some nursing home care and how it would be financed?

Mr. HAGEN. We are in the process of gathering that information now.

Senator GLENN. We would appreciate it if you could give us that information when it is completed.

Did most of the respondents feel Medicare would pay?

Mr. HAGEN. Yes; I think the most startling finding, but maybe not surprising at the same time, is that most, 79 percent, fully thought that Medicare would pay for some, if not all, of the costs associated with chronic care conditions, institutional home care, as well.

Interestingly, also, though, only about 10 percent of the same group of people we talked to thought that their adult children would be in a position of paying, nor would they ask them to pay for that care.

Senator GLENN. I noticed that on the chart, respondents listed children at 10 percent—which was surprisingly low to me.

Mr. HAGEN. Yes; I think for some of the same reasons both you and Senator Heinz indicated earlier—family patterns, moving apart, and a number of other things.

Senator GLENN. My time is up, Mr. Chairman. But I do not think I am an untypical family. I am in Washington, with a daughter in

Colorado, and a son in San Francisco. That is not unusual these days, where we used to have people grow up and stay in the same community, town; they assumed responsibilities, and if they had problems, they could call on the help of people they had lived with all their lives. We are a mobile, flowing society, as I indicated in my statement; 20 percent move to a new domicile each year, and 13 percent cross State lines. I think these are the current figures.

Thank you, Mr. Chairman.

Chairman **Heinz**. Senator Glenn, thank you.

Senator Warner.

Senator **Warner**. Thank you, Mr. Chairman.

I commend you and the ranking minority member for this hearing. I have an interest both as a Senator and as a parent. My brother and I are privileged to have a mother who is 95 years old. She is strong of mind and strong of body, and she still gives me a little advice everyday. I have experienced with my brother first caring for mother in the home and now, of course, in a nursing facility, and I am well familiar with the problems, visiting there on an average of three to five times a week, and with staff and other persons living there.

A question momentarily to Mr. Hagen, but first to the Chair. It seems to me, as we address this critical problem, we should also view the tax aspects and tax credits. I know the chairman has introduced legislation in the past, the purpose of the legislation to enable children who take care of their parents to have some tax relief.

So my question to Mr. Hagen is—while you did not address this in your testimony, I presume your association has examined the Federal Tax Code as a possible means of also working in concert with what insurance programs we may have for the future.

Mr. **Hagen**. Yes; we have, Senator Warner. As a matter of fact, a number of years ago, I believe Senator Heinz introduced a bill which our tax people at the association, our legislative people, were very much involved in and supportive of. I think it is reflective of the same concern that was just raised by Senator Glenn, as well, of the extended family situation, the person working in Washington, having an older parent in St. Louis or in California someplace, and really, truly wanting to help, but not being close enough to provide the hands-on kind of care that is necessary.

Chairman **Heinz**. May I say to my friend and to Mr. Hagen that the bill number is S. 1301, which we introduced last year.

Senator **Warner**. Perhaps the Chair could tell us about what intentions you have with respect to presumably the next session of Congress. It seems to me I would like to join with you in this effort, and maybe this committee could have a joint hearing with the other committee, the Finance Committee, of which you are a member.

Chairman **Heinz**. Senator Warner, I would be delighted to join with you. You have been very supportive of this legislation. This would have been my preference to try and enact it this year. This was a year in which we were cutting back on tax-preference items, but next year, I hope, in the context of looking more comprehensively at our tax system, that we will make some choices, and we can incorporate S. 1301 in whatever we enact.

Senator **Warner**. Well, soon we will hear from a panel of policymakers, but it appears to me that, to the extent the private sector—and in that sense, I refer to children as opposed to Government subsidies—to the extent the private sector can deal with this problem—and the tax relief would be an essential part of that—the better off we are, because I agree with Mrs. Thomas. While my mother today is very comfortable, we certainly enjoyed having her at home to the extent that we could.

Thank you for coming today, Mrs. Thomas. You are an inspiration to all of us.

Chairman **Heinz**. Thank you, Senator Warner.

Senator Burdick, before you begin questioning the witnesses, would like to make a statement?

Senator **Burdick**. Thank you, Mr. Chairman. I ask that my statement be entered into the record.

Chairman **Heinz**. Without objection, Senator Burdick's statement will be entered into the record at this time.

[The statement of Senator Burdick follows:]

Statement of Senator Quentin N. Burdick

Mr. Chairman, I have just a short statement. I am very pleased that you are holding this hearing today. You may not realize it, but it builds on a field hearing I held in Bismarck, ND, in 1982. That hearing was entitled, "Health Care for the Elderly: What's in the future for Long Term Care?" The major topic that day was the need for more alternatives to nursing homes—but a second major topic was the high cost of nursing homes and the great difficulty people had paying for that care as well as other long-term care alternatives.

That hearing was a lively one. There was fear, anger, and frustration expressed that day as people talked about their limited options and the difficulties they had experienced. It showed me how deeply this issue affects people, and how badly we need to find some solutions.

There are no good alternatives as yet to pay for long-term care. I hope this hearing will help to point the way to some solutions, for they are badly needed.

Senator **Burdick**. I would like to address my question to Mary Kinslow. Your suggestion of day care for the elderly is rather intriguing. We understand how day care for children works, because generally, the breadwinner has a job, and somebody takes care of their youngster when they are gone.

Now, I presume invariably that an elderly person would have some ailments, and they will get more ailments as they grow older. How does this work out in practice? Is there any medical care at your place or any other places?

Ms. **Kinslow**. We are a social day care, and most of our clients, if they are on medication, are self-medicated, with guidance.

The interesting thing that you are going to find is that seniors are no different than you or I. When you have a routine, when you are used to getting up, and you are used to going, and you are used to being involved, you are going to feel much healthier than the senior who is sitting home and actually wasting time, important time. They have a lot to offer. They have a lot to share with other people, and it gives them the opportunity to do this daily. They have remotivation skills; they have reality orientation for the confused senior. It is just a multitude of wonderful things brought together throughout a day, and instead of the senior taking from the family, at the dinner table, they have something to contribute at the end of the day.

Senator **Burdick**. Well, I think that is fine. And as I say, I am intrigued. But what do you do about the elderly who, as happens often, may have to use a walker, or a cane, or a crutch, or something like that?

Ms. **Kinslow**. That is all right.

Senator **Burdick**. Do you have the facilities to handle things like that?

Ms. **Kinslow**. Yes, we do. We are entirely ramped, and we have all the handicapped equipment that would be necessary for anyone with a wheelchair, a walker, anything of that nature.

Senator **Burdick**. And I presume this situation occurs more or less like it does for the children; the breadwinner of the house is working and cannot stay home, and this is the next best method?

Ms. **Kinslow**. That is right.

Senator **Burdick**. I think it is worth looking into.

Ms. **Kinslow**. Thank you.

Chairman **Heinz**. Ms. Kinslow, you mentioned in your testimony that you received some letters from other families.

Ms. **Kinslow**. Yes, I have.

Chairman **Heinz**. Are you in a position to share any of those letters, or even just one of those letters, with us?

Ms. **Kinslow**. Certainly:

> I read about your wonderful organization in the Daily News, in the "Dear Abby" column. It was a Godsend. I am at my wits' end, and I do not know what to do. My father had a stroke in September 1979. He has continually gotten worse, because he has given up, and he wants to die.
>
> He will not go for therapy, and last September, he had a small stroke, which took the rest of his speech. He has aphasia, and uses one word for everything. He does say other things, at times, and he can pray with no problem. He is always praying to die.
>
> I quit my job last September to care for him and my mother at their house. I would be there during the day, and my brother who lives there was there at night. But my father just got too much for them, so I had him transferred by ambulance to my house.
>
> I got a hospital bed set up in the living room and a commode. Our house is small, only two bedrooms, so this is the only place that I can put him.
>
> We have looked into nursing homes, but they are all so expensive. My parents have savings of about $20,000, but that would only pay for about a year. And, if all the money is used, and my mother would get sick in 5 years, there would be nothing. From what I am told, they take all but $1,500, and then you can apply for a grant. But they put a lien against the house. My mother could live her life, but then they take the house. The problem is, my brother lives there, and my parents have the house left to him as the survivor. He helped pay for the house and has made repairs and paid for all that. I just do not think it is fair that the State takes something my brother has been paying for. If we change it to his name, I hear they will come back and take it anyway.
>
> We are living day-to-day, but I do not know how long I can do it. It is like having a 175-pound baby. He gets me up three or four times a night, and he wants constant care all day.
>
> How do people deal with aging parents who are stubborn and contrary? I pray for patience every day, but I am afraid I am going to end up with an ulcer.
>
> My husband is very helpful and understanding, but our life is not our own. And I have a 4-year-old son whom I placed in a day care center so he could be with other children instead of here.
>
> Any help or advice you could give me to help me cope with this would greatly be appreciated.
>
> Looking forward to hearing from you, Sincerely.

Chairman **Heinz**. And that is not a totally unusual letter?

Ms. **Kinslow**. It is a normal letter, Senator. This is not uncommon at all.

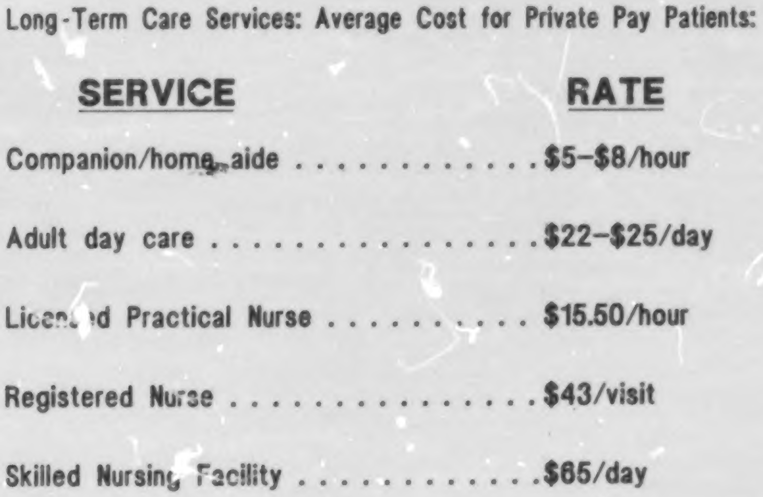
Chairman HEINZ. You come from Levittown, and that is in Bucks County, PA, just north and slightly east of Philadelphia.

Ms. KINSLOW. Right.

Chairman HEINZ. What would long-term care services cost in Bucks County?

Ms. KINSLOW. On chart 4, we have companion home aide. A companion home aide is one who would come in and stay with an elderly guest, maybe prepare a lunch, general helping, at the rate of $5 to $8 an hour.

CHART 4



Long-Term Care Services: Average Cost for Private Pay Patients:

SERVICE	RATE
Companion/home aide	$5–$8/hour
Adult day care	$22–$25/day
Licensed Practical Nurse	$15.50/hour
Registered Nurse	$43/visit
Skilled Nursing Facility	$65/day

Survey of Services: Children of Aging Parents

We have an adult day care rate, which would range anywhere from $22 to $25 a day at some clinics.

Licensed practical nurses, coming into the home to, say, give an injection for a diabetic or something of this nature, would be $15.50 an hour.

A registered nurse who would come in primarily for the skilled care nursing within the home, would be $43 a visit.

And our skilled care nursing facility runs approximately $65 a day in Bucks County.

Chairman HEINZ. I thank you for having prepared that chart. This is based, I understand, on a survey that your organization, Children of Aging Parents, has done.

And I would just say for the benefit of my colleagues on the committee, Levittown is a working-class community; many of the people there are steelworkers, second generation Americans. It is not one of the wealthiest communities, it is not one of the poorest. It is a fairly typical American area. And I think we would all agree that those prices are not exactly affordable to people today.

Let me just ask a quick question of you, Ms. Kinslow, or Mr. Hagen.

Is there any insurance available to cover any of these costs that you can get from the Federal Government or from Blue Cross or from anybody else? Do you know any insurance policies that would help pay for any of these costs?

Ms. KINSLOW. At the present time, we are aware of several insurances that will help pay toward these various costs. Again, it is a very frightening thing, because they are not written well; they are not self-explanatory. There is marginal coverage, and existing illness clauses, various things.

The one thing that I found unique when we called many of these companies to look further into their policies, they were very vague on the phone. And I understand it is new for them, but before people put their life savings and plan for the future with these policies, we have to understand that when the time comes, they will cover and take care of our——

Chairman HEINZ. And you are saying it is just unclear as to what they are going to do?

Ms. KINSLOW. Very unclear.

Chairman HEINZ. Mr. Hagen, your organization's survey, I think, is extraordinary. In the first case, it shows that 4 out of 5 Americans, 79 percent, think that Medicare is going to help them with long-term care, home health services or nursing homes.

Mr. HAGEN. Right.

Chairman HEINZ. I think we all know the answer, but will you tell us exactly how much Medicare will pay for either home health care services or nursing home care?

Mr. HAGEN. Well, I think it is clear that Medicare only pays for Medicare-certified skilled nursing care, and it does not pay for intermediate or custodial care, the primary care that people with long-term chronic care conditions need. On the home care side, I know everyone here does know that you have to require skilled care on a part-time intermittent basis, and you have to be homebound to receive that care, and there are very few, if any, insurance policies, private insurance policies, that cover anything beyond that Medicare definition of home care.

Chairman HEINZ. There is one other qualifier on the care. You have to either have an acute illness, or have a bout with an illness from which it is judged that you can recover, and the moment it is judged that you have an illness from which you cannot recover, we cut you off.

Mr. HAGEN. That is right.

Chairman HEINZ. Whether it is skilled nursing care, homemaker services, home health aide, or whatever?

Is that not accurate?

Mr. HAGEN. That is correct, Senator. And most of the medi-gap policies that exist today do require that you be in a Medicare-certified facility, as well.

Chairman HEINZ. Well, that was my second question. I want to ask you about medi-gap policies. They are really the third item down there. One out of two Americans believe that private insurance is going to help them—and I think what they have in mind are these medi-gap policies. Do they help in terms of the kind of long-term care that we have been talking about today, the need to deal with some of the risks of growing older—namely, when you get older, there are certain kinds of things you do not really fully recover from.

Mr. HAGEN. They really do not, Senator. What they do cover, as I said, is skilled care in a Medicare-certified facility, for the most part. They do not cover the long-term institutional situations where intermediate or chronic care, custodial care, is needed. It is an unfortunate situation, I guess, in a certain sense. But there are some companies now, on a very limited basis, that are starting to look at covering intermediate or custodial care, but for the most part that is not a private insurance coverage that is available.

I think the interesting thing here, too, is that we asked individuals under the age of 65 within our membership whether they were in fact covered or not covered in the group, as well as individual health insurance sense, and they also were under the impression that they were covered when, in fact, they are not, for the most part.

Chairman HEINZ. Mr. Hagen, my time has expired.

Senator Glenn—and I notice Senator Johnston has come in, and we will yield to him.

Senator JOHNSTON. I have no questions at this time, Mr. Chairman.

Chairman HEINZ. All right. Senator Glenn, I understand you have further questions.

Senator GLENN. Thank you, Mr. Chairman. I do, briefly.

The need is there—we all know that. And yet we know, also, that all the needs of the elderly—health and nutrition and housing and so on—we are not going to be able to take care of all of it with a Federal program. Let us just start with that. We all realize that. And I am curious as to what part of this you think should be local, State, Federal. And I guess from your own experiences with this, I would ask each one of you to respond to what should receive our priority here—I guess that is what I am asking. Where should we spend funds if we are to meet the greatest need to help the greatest number of people. I know that is a broad-gauge question, but it is something we have to face. And if you were sitting in our positions here, in private committee session up here, and on the floor, and you were debating these things, and you want to put in an amendment, you want to help as many people as you possibly can, what would your best advice be as to where we should put our priorities?

Mr. Hagen, would you lead off on that?

Mr. HAGEN. I think in a very limited sense, maybe the most limited sense, possibly, but maybe the most challenging sense, is the educational and informational needs. I think there has to be a much greater effort to education and inform our older Americans as to what they currently have, what Medicare pays for, what it does not pay for; what is Medicaid; what is private insurance, medigap insurance—what does that pay for and what doesn't it pay for. I mean, that is a very basic situation that has to be dealt with, I think, on an immediate basis.

Longer term, I think some of the issues we have discussed today--taking a look at the Medicare home health care benefit and seeing what that is doing in the way of meeting true needs; taking a look at the Medicaid situation and the institutional bias that exists there, and trying to write that balance, possibly.

But I think the basic thing that we have found, time and time again, and the kinds of situations we see every day of people having to deplete resources and spend down, is that there is such little real knowledge about what they currently have and what private and public insurance pays for. I think the Federal Government, State governments, insurance regulators at the State level have a responsibility, as well as associations like ours, to do everything we possibly can to at least inform people of what the current situation is.

Senator GLENN. Yes; that is a very good point, and I think the committee can do something on that information thing. I am sure we could help out at least some in that particular area. Once you get by that, though, let us say people completely understand the whole system—then, where is the greatest need, where is the greatest gap that we could help cover?

Mr. HAGEN. I think the home care side, quite honestly. I think that we need to do something to loosen up the definition of skilled intermittent care, rehabilitation potential on the institutional side that is require. I think there are such restricted definitions there that we are meeting just not even the tip of the iceberg as far as need is concerned there. There has to be a greater realization that it is not only acute care, but it is long-term care, where there is real and very substantial liability for these folks.

Senator GLENN. Thank you.

Ms. Kinslow, would you address that?

Ms. KINSLOW. Senator Glenn, I am sure you are well aware that only 5 percent of our graying seniors end up in the nursing homes. A large majority of our elderly are being cared for by their family members. If this trend continues, and if ways can be found to supply the needed respite for the caregiver, they would be encouraged to do more for a longer period of time, and in thus doing so, save the taxpayers enormous amounts of money in the long run.

Senator GLENN. Mrs. Thomas, do you or Ms. Rascher wish to comment on that?

Mrs. THOMAS. Well, Senator, I had nobody. All my brothers and sisters are dead. I had nobody. So I cannot say.

Ms. RASCHER. So what she needs is someone who is going to guide her through the system. You can have all the information you want on a system, but to understand it and know how to use it is a whole different story. I would totally agree with everyone on this board. You need that information, you need that home care support to give the care givers relief so that they can continue, so that the care giver does not die before the elderly person does—and we have had that happen.

Senator GLENN. Thank you very much.

Thank you, Mr. Chairman.

Chairman HEINZ. Senator Glenn, thank you.

At this point, I would just like to summarize what I think we have learned today, to be sure that we have all our facts straight. I will not do justice to it all. We have learned that there is a lot of confusion about the extent to which you or your parents, our parents, have any coverage from Medicare or medi-gap insurance. Most of us have very little coverage indeed when it comes to nursing home care or home health care, the very sources we would need if stricken with a debilitating, particularly a progressive illness, or an illness where the prospects for rehabilitation range from poor to nonexistent.

The second question is, what can be done about it, and what are the options. One of the things that has been proven by Mrs. Thomas and Ms. Rascher is that expert advice may not solve all the problems for those who need long-term care, but it will help people to avoid some of the worst pitfalls and problems. And there are currently two kinds of places to go. One type of place might be a county adult services bureau, or if you are lucky, something akin to the channeling project that we have in Philadelphia. The other end of the spectrum, frankly, I would say, much like Mary Kinslow's organization, a nationwide voluntary channeling project where people help people, to avoid some of the same problems that Mrs. Thomas got into. This kind of voluntary self-help channeling project directs people to get the most bang for the buck, to avoid losing those $66,000 worth of savings unnecessarily, as Mrs. Thomas did

I think there is also an implication that we have a bias in our existing system. To the extent that we cover nursing home care, Medicaid, not Medicare, will pay for it. But if you have enough Social Security income, you will be disqualified for the kind of care most people would rather have, namely, home health care, even though home health care is less expensive, and allows you to maintain your independence and dignity. Adequate care in the home also allows people like Mrs. Thomas to meet her family responsibilities. And that is why I think Mr. Hagen's summary is absolutely correct, saying that the single most important area, if we had only one to address, would be the provision of home health care. And the surveys I have seen show that three-quarters of the people just do not want to go to a nursing home under any circumstances, and they would like help with home health care, if that is what is required, because that is what they most want.

I did not see anybody shaking their head saying, "No, Senator, you missed it, you did not understand the problem." That being the case, I thank you all very much——

Senator **Glenn**. Just one more question, John.

Chairman **Heinz**. Senator Glenn, I will be happy to yield to you.

Senator **Glenn**. Those of you who work in this field all the time, how much of this would be preventable by better health care, nutrition, things like this, at an earlier age? Is that a major factor in this, or is that a minor factor, that we just all are going to get old sometime and have problems? Medical checks—in other words, I was thinking along the lines that you were talking about that better information would prevent some of this catastrophe from happening and people getting in bad shape. Well, the other thing is, how do you prevent people from getting in bad shape to begin with? Is that a major factor, or is it not?

Mr. **Hagen**. Yes, I think it is. I think you have hit on a very important point, Senator. I think one of the points I made when I spoke earlier was the fact that we are doing such a good job on the acute care side that we are having people with longer lifespans, and therefore, the incidence of chronic conditions are much greater. I think there has to be some attention educationally, programmatically and informationally, to what these chronic conditions are, what they are all about, and how they possibly can be prevented. I think you are absolutely right.

Ms. **Kinslow**. Very good, Senator. I agree with Ron—more education—a healthier mind is a healthier body.

Senator **Glenn**. Brenda?

Ms. **Rascher**. Definitely, Senator. Even after they get sick, it is important to learn the preventive aspects even then, to prevent getting worse. We have to remember that this is maintenance once you get sick, and prevention so you do not get sicker.

Senator **Glenn**. Thank you.

Chairman **Heinz**. Senator Burdick?

Senator **Burdick**. I want to ask about a scenario that may sound extreme, but I have experienced this and know about it. Mr. Hagen says that medi-gap and Medicare does not take care of it. We now say that we can get some help from the home care, but that costs money. Some of these families that I know about have spent thousands and thousands of dollars and have impoverished themselves. They cannot afford home care.

What happens to that elderly person, that grandmother or that mother? What happens if we do not have any help at all from these areas we were just discussing? Where do they go?

Does anybody have an answer?

Ms. **Rascher**. They generally go to a medical assistance nursing home bed. They usually wind up there eventually. Even if the family does not really want them there, that is where they wind up.

Senator **Burdick**. Who pays the bills?

Ms. **Rascher**. Medical assistance.

Senator **Burdick**. I see. Then, there is some fallback, someplace.

Ms. **Kinslow**. There is, I know, in Bucks County, in Doylestown, they have Nishaminy Manor for medical assistance, primarily. The only problem is it has such a connotation about it—it was once the county poorhouse.

Senator **Burdick**. I understand. Thank you.

Chairman **Heinz**. If I may offer an answer to your question based on what I have in my our own State. In Pennsylvania, and in other States, there are not enough nursing home beds, even for the indigent Medicaid population. As a result, we now have this subclass of facilities that, in our State, go by the rubric of "boarding homes." They are not where you and I would go to board. They are often filled with very old, very incapacitated—I hesitate to use the word "sick"—but very incapacitated people, who are, to my untrained and unpracticed eye, indistinguishable, in terms of their health conditions, from the people you will find in many intermediate care and skilled nursing facilities. The boarding homes will, in effect, their Social Security checks—and that is the deal. The quality of medical supervision in them varies all over the lot, ranging, I guess, from adequate to nonexistent. And that remains a concern and problem in our State and I imagine in many others.

I want to thank our panel, especially Mrs. Thomas, who has made a heroic effort to come down here. Mrs. Thomas, this is your first trip, not just to Washington, but out of your house in 3 years. [Applause.]

We hope to make it all worthwhile so that other people can avoid the kinds of problems that you have had. I think you are pretty lucky to have found someone like Ms. Rascher to give you a hand, too. She deserves all our thanks, as do you.

Thank you all very much, and I would ask our next panel to come forward.

Mrs. **Thomas**. Thank you very much.

Chairman **Heinz**. Our next panel consists of Betsy Houchen, director of the Columbus Home Health Services, who I think Senator Glenn introduced earlier; Nancy Versnick, chairperson of the long-term care insurance task force of the American Health Care Association; and Jim Sykes, chairman of the public policy committee.

Let me ask Betsy Houchen to proceed with her testimony, and then I am going to yield to Senator Glenn—excuse me—I think I should yield to Senator Glenn now, in case he wants to introduce Betsy at this time.

Senator **Glenn**. Thank you, Mr. Chairman.

I mentioned earlier in my statement about the work that I know of first-hand in Columbus that she has been doing there, because I live in that community, in that town, and we are very proud to have her here today to testify and give us some of the benefits of her experience there.

Betsy, welcome to the hearing.

Chairman **Heinz**. Betsy, please proceed.

STATEMENT OF BETSY J. HOUCHEN, DIRECTOR, HOME HEALTH SERVICES, CITY OF COLUMBUS, OH

Ms. **Houchen**. Thank you.

Mr. Chairman and members of the committee, my name is Betsy Houchen. I am the director of home health services, city of Columbus, OH. I am also the assistant health commissioner of the Columbus Health Department.

I am here to testify on behalf of my own agency and the National Association for Home Care, of which we are a member agency. The National Association for Home Care is the Nation's largest professional organization representing the interests of over 2,000 home health agencies, hospices, and homemaker/home health aide organizations.

We would like to commend you on holding this important hearing. We believe that the long-term care insurance issue is of critical importance to explore in light of the projected insolvency of the Medicare trust fund, the overall need for health care cost containment, and the problem of the inordinate out-of-pocket expenses the elderly have to bear for overall health care, despite Medicare.

Society should take responsibility for the risk of chronic care. Society has taken responsibility for other major risks faced by our older population–for example, loss of income in retirement, Social Security, and acute medical care, Medicare. There must be similar public, private, or joint responsibility with regard to chronic care.

The trends leading to the current interest in long-term care insurance include: One, an older and more frail population, particulately the 85-plus group, who are more likely to outlive their resources and therefore are more dependent on Medicaid; two, cutbacks in Medicaid; three, an institutional bias by Medicaid; four, an acute care bias by Medicare; and five, the lack of chronic care models for clinical and reimbursement purposes, recognizing preventive care as an integral part of chronic care.

The fact that the older the person, the more likely chronic disease patterns will emerge makes it more imperative to seek funding mechanisms responsive to those needs. Without this support, inappropriate care, premature institutionalization and a sicker population are likely.

Although long-term care is usually discussed with regard to the elderly population, we feel it is important to recognize that long-term care encompasses all ages, since the chronically ill are not all elderly. Pediatric care and the needs of younger as well as older adults requiring chronic care must be addressed in any discussion of long-term care needs.

While we are advocates for appropriate care at whatever level, we feel that strong consideration must be given to building in a significant home care component to any long-term care insurance plan. Few existing plans cover home care, which reflects the traditional institutional bias in the health care system. We feel that the focus of long-term care should be redirected to emphasize a noninstitutional setting. This is not only a more humane alternative, but also a more cost-effective solution. Utilizing home care will reduce expensive institutional costs allowing middle income people to pay for their own long-term care costs.

There is a vast amount of evidence of the cost-effectiveness of home care, both from studies by home health agencies, the Federal Government, and the major private insurance companies. We have previously submitted these studies to congressional committees and would be pleased to provide them to this committee.

The need for long-term care insurance, with a strong home care component, is critical in light of the current coverage gaps in both Medicare and private insurance. My agency sees a substantial number of patients who are covered by private insurance. Approximately 10 percent of our admissions are private insurance patients. There are a number of problems regarding coverage by private insurance.

First, there is insufficient coverage of skilled care and supplemental insurance is inadequate. Supplemental insurance plans do not cover any care which is not covered by Medicare, so if Medicare will not pay for a service, the supplemental insurance will not cover the service, either. The only thing that the supplemental policy will pay is the 20 percent over the 80 percent coverage that Medicare pays. This frequently leads to patient confusion, since most patients with supplemental policies believe that these policies will pay for services not covered by Medicare.

Let me give you an example. We have a 65-year-old female patient with a total knee replacement and severe arthritis. A physical therapist visited her in her home, with Medicare covering the visits. When the patient was no longer homebound, the physical therapist wanted to continue giving her exercises to make her more ambulatory, but we could not bill Medicare, since a patient must be homebound to qualify for the home health benefit. We attempted to bill the patient's supplemental insurance plan, but the insurer said that they would not even consider reimbursement if Medicare did not cover the service. The patient is now paying $2 per visit, and we are writing off the remaining $38 of the charge per visit.

A further problem regarding existing private insurance coverage concerns maintenance or preventive care. Private policies may cover nursing, but frequently, do not cover home health aide service or rehabilitation service. One of our patients was a 73-year-old man with Parkinson's disease and a colostomy, who was totally bedfast and required total care. He had to be fed, bathed, dressed, and could only be moved from bed by a Hoyer lift. He received nursing care, physical therapy, occupational therapy, and home health aide services. The occupational therapist made a splint for his hand, which had already become deformed, and she was teaching his wife the schedule for splint-wearing and range of motion exercise. The home health aides assisted the patient's wife in giving him personal care. His insurance company paid only for nursing visits, but not for occupational therapy or home health aide visits.

A person, such as this patient, with Parkinson's disease has definite needs, even though he or she is not acutely ill. Insurance companies consider this custodial or nonskilled maintenance care, so neither they nor Medicare will even consider paying for this type of care. We could help patients such as these at home at a lesser cost, but insurance companies just will not pay for it.

Our agency provides a great deal of maintenance care. The elderly, by reason of their age, need supportive services. This is precisely what their insurance companies are not paying for. Long-term care insurance must cover supportive services, not just nursing and rehabilitation. Personal care, housekeeping, and chore services are all essential services for inclusion.

Our agency has been one of the participants in a HCFA-funded demonstration project where aid for dependent children recipients are trained as homemaker/home health aides. This project has worked extremely well for our agency, since much emphasis has been placed on training, orientation, and supervision. Last year, we had 20 participants in this program, who provided service to over 200 patients and averaged approximatly 300 visits per week. This is significant, because the recipients of these services received care which otherwise would not have been possible because there would have been no payment source if they had not been in the demonstration project.

Because of the increased number of home health aides in the community as a result of the project, the service recipients were able to remain in their homes rather than going into nursing homes.

For example, a couple in their nineties received assistance from home health aides in this program. The couple lives alone and want to remain at home. They receive services five times a week. The homemaker/home health aide prepares breakfast and lunch and takes almost total care of the home, including laundry, cleaning, and all personal care for the husband and wife. Their daughter is unable to assist in their care due to illness. Other family members work, but do assume some responsibility in the evening hours. Were it not for our services, this couple would be forced to go to a nursing home.

We need more long-term solutions. Demonstration projects, though helpful, are finite. With long-term care insurance plans which provide both skilled care and aide services, couples such as the one just mentioned would not have to be unnecessarily institutionalized.

I hope that I have provided you with some insights regarding the gaps in the current insurance coverage, why long-term care insurance is urgently needed, and why home care is such a vital component in any long-term care plan.

I would be pleased to assist the committee in exploring these important issues.

This concludes my statement. Thank you for the opportunity to appear today.

Chairman **Heinz**. Ms. Houchen, thank you very much. We will have questions for you at the conclusion of the testimony of the other panelists.

Let me at this point call on Nancy Versnick, representing the American Health Care Association.

Ms. Versnick?

STATEMENT OF NANCY VERSNICK, WASHINGTON, DC, CHAIRMAN, TASK FORCE ON PRIVATE LONG-TERM CARE INSURANCE, AMERICAN HEALTH CARE ASSOCIATION, ACCOMPANIED BY ROBERT BENNEDICT AND LAURENCE LANE

Ms. **Versnick**. Good morning, and thank you, Mr. Chairman and members of the committee.

I am Nancy Versnick, chairman, Task Force on Private Long-Term Care Insurance, American Health Care Association. The American Health Care Association is the largest national organization of long-term care providers, representing nearly 8,000 licensed facilities. We are honored by this opportunity to appear before the U.S. Senate Committee on Aging to discuss the private insurance coverage for long-term care services.

Accompanying me this morning are two experts in the field, former U.S. Commissioner on Aging, Robert Bennedict, currently State executive of the Pennsylvania Health Care Association, and Laurence Lane, of the American Health Care Association staff.

Chairman HEINZ. Ms. Versnick, on a personal note, just let me say that I am quite familiar with both of your experts, and they indeed are. Larry Lane has been before me, when I served on various committees—I hate to say it, for his benefit, and this will not protect him, but back when I was in the House of Representatives, he was an expert even then. And Bob Bennedict, although he has become famous down here in Washington, DC, with his responsibilities, was famous in Pennsylvania as the director of—I guess, Bob, it was then—it was before we had a department of aging, so I guess it was simply an office on aging. Just think, if you had stayed, you could have been a secretary; it is better to be a director, I guess. [Laughter.]

Nancy, please excuse me.

Ms. VERSNICK. That is all right, Senator. I am glad that they are recognized as experts in this field.

Chairman HEINZ. They are getting more difficult as they get older, but they probably feel the same way about me. [Laughter.]

Ms. VERSNICK. There is a growing consensus among our members that private insurance offers a promising approach to purchasing quality long-term care services. I wish to briefly share with this committee: One, the reasons for this support of private insurance; two, the minimum coverage principles; and three, the findings of a study which we prepared earlier this year, discussing the availability of private insurance for long-term care, obstacles to expansion, and actions which our association sees as necessary to develop the market.

At the outset, let me emphasize that we believe the exposure for costs of long-term health care services is an insurable risk. This perspective is shared by a number of companies underwriting the costs of such services, by the academic community, and by the Health Care Financing Administration of the Department of Health and Human Services. No longer should the question be can there be private long-term care insurance; the policy questions now should relate to timing of market development, the nature of coverage provisions, and the relationship of the private market to public programs.

Our private long-term care insurance task force has identified six items as important reasons for public pursuit of private insurance for long-term care: One, provides financial support for purchase of quality service; two, enhances the opportunity for consumer choice; three, preserves the dignity of older persons to prudently plan for their potential long-term care needs; four, reduces Federal and State exposure for the costs of future long-term care services; five, overcomes the reliance upon public programs as the source of payment for services; six, assures market competition as a source of payment for services; and seven, assures market competition and induces the expansion of diversified service delivery.

While this is not an exhaustive list of reasons, the point is clear that developing private insurance coverage will benefit the consumer, insurers, Government, and providers.

Inducing a positive response from the private insurance sector will require a constructive dialog. The recently released report of the Health Insurance Association of America, entitled "Long-Term Care: The Challenge to Society," offers a useful framework for stimulating the public debate.

In a similar cooperative effort, AHCA has sponsored a series of policy forums at the national and State levels. Attached to my testimony is a summary of the proceedings of our national policy forum.[1] We are working cooperatively with consumer and government groups to put together another national meeting.

Our initiatives are guided by 10 points to develop the insurance market. While these 10 points do not reflect an official position of our association, they are representative of the input which we are receiving from our members:

One, long-term care insurance must truly reflect financing for the longer stay patient in need of skilled and/or intermediate care.

Two, long-term care insurance should not be tied to Medicare part A requirements nor linked to definitions of levels of care utilized by the Medicare Program.

Three, approved utilization screens should be based upon geriatric service needs.

Four, long-term care insurance should reflect payment for both institutional and noninstitutional long-term benefits provided that the same geriatric screen criteria for utilization be used to ensure prudent utilization of the coverage.

Five, long-term care insurance should afford the opportunity for children and others to purchase the coverage on behalf of a qualifying relative and for the purchaser to receive the benefits of available taxation deductions and credits.

Six, an indemnity insurance approach is acceptable provided: First, the rate reflects the true costs of providing necessary services to an individual, and second, the rate includes a trending factor to compensate for inflation.

Seven, eligibility criteria should not negate coverage for a large number of older person, that is, policy exclusions should not prevent coverage for chronic conditions closely correlated with the normal aging process.

Eight, preexisting condition requirements of a policy should be time specific.

Nine, policies which offer reimbursement based upon resource utilization should be inflation indexed to reflect the true costs of care; and

Ten, strengthening of the private insurance market should be synchronized with changes in the Medicaid Program so as to promote the private approach without abandoning current Medicaid eligible populations.

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[1] Retained in committee files.

Earlier this year, staff conducted a study for the American Health Care Association of the private insurance market. Findings document that private long-term care insurance coverage is available, affordable, expanding, and adequate.

The report indicates that over 25 insurance companies are experimenting with policies covering extended long-term care services. Of that number, more than half have made a commitment to expanding their share of the market. While the experimental policies greatly vary, the typical policy provides an indemnity benefit of between $30 to $60 per day for coverage of skilled nursing and intermediate care services for up to 4 years of nursing home placement. It appears realistically possible for an individual between the ages of 60 and 65 to purchase viable long-term care insurance at a premium of less than $30 per month. While coverage for an individual above the age of 75 will be more expensive, data on the income and resources of older Americans suggest that long-term care insurance is well within the means of most senior citizens.

Among the most significant obstacles to the growth of the private long-term care insurance market are consumer underestimation of their potential need for long-term care coverage and overestimation of the available coverage of their existing policies and of public programs.

The study concludes that a variety of approaches can be taken to make long-term care insurance a reality across the country. One of the key recommendations of the report is for the American Health Care Association and its State affiliates to assume the leadership in spearheading coalitions with other interested groups to promote the marketing of long-term care insurance. Such initiatives would work to raise public consciousness of the need for insurance coverage, entice the cooperation of major insurers to extend coverage into the long-term care market, and cooperate with Federal and State government officials to secure necessary legislation to make private insurance viable.

This hearing is a pioneering effort focusing attention on a void in our programs for older persons. While a number of States are exploring the role of private long-term care insurance, Minnesota, Connecticut, and California, through study resolutions, and Kentucky and New Jersey by legislation, this is the first comprehensive Federal review.

Medicare provides scant coverage for nursing home services and other long-term care. Supplemental insurance policies, so-called medi-gap coverages, use Medicare definitions. Most policies are restrictive in coverages and provide no real protection against long-term care costs. Without Medicare or insurance protection, individuals must rely upon their own savings to pay for long-term care services. Nursing home expenses are the largest catastrophic expense for individuals age 65 and over. Many people spend their resources until they are so poor as to be eligible for Medicaid. To the extent that private insurance can help people from needing Medicaid, the costs to government for supporting the indigent could be reduced.

The members of our association stand ready to work with you in this challenge of enticing usable private long-term care insurance policies.

Thank you for allowing me the opportunity to appear before this committee.

Chairman HEINZ. Ms. Versnick, thank you.

I believe Senator Glenn has a comment.

Senator GLENN. Mr. Chairman, I have to go to another meeting, and I will try and get back a little bit later. I am sorry I cannot be here. I want to thank you all for being here.

And also, in Ms. Houchen's statement, she indicated several studies on the cost-effectiveness of home care by HHA's, the Federal Government, and major private insurance companies and offered to provide the committee with copies of those documents for our information. I am looking forward to receiving those studies.

Chairman HEINZ. Senator Glenn, thank you.

Mr. Sykes, representing the National Council on the Aging. Jim, please.

STATEMENT OF JAMES T. SYKES, MADISON, WI, CHAIRMAN, PUBLIC POLICY COMMITTEE, NATIONAL COUNCIL ON THE AGING, AND SPECIAL ASSISTANT TO THE VICE CHANCELLOR, CENTER FOR HEALTH SCIENCES, UNIVERSITY OF WISCONSIN-MADISON

Mr. SYKES. Thank you, Senator Heinz.

I am Jim Sykes, chairman of the Public Policy Committee of the National Council on the Aging, and special assistant to the vice chancellor, Center for Health Sciences, at the University of Wisconsin-Madison. I am also the founder and chairman of the Colonial Club, a community-based senior center surrounded by elderly housing which provides comprehensive, community-based, long-term care services, not including a nursing home.

It is from these perspectives, but on behalf of the National Council on the Aging, that I appear today to urge this committee to continue its search for a coherent, responsible, humane policy to provide and fund the long-term care needed by those suffering from chronic conditions, those for whom supportive services within the community are unavailable, those threatened by the fear of total loss of independence due to the high cost of long-term care and their declining ability to remain in the community. These individuals are surely among those in greatest need in our society, least able to defend themselves against personal and financial losses, and dependent upon a caring society. How this Nation responds to these individuals and their families is surely the clearest test of our commitment to humane values.

It is well-established that a long-term care system has at least four components. A long-term care policy, to be coherent, responsive, and humane, must provide for those elements which truly assist individuals in need within the community as well as within the nursing home. A policy discussion that focuses only on cost containment is misguided. To an unfortunate extent, that is the case here in Washington, in our State capitols, in the media, and most unfortunately, in the minds of persons at risk and their families.

Looking quickly at these often overlooked parts of the long-term care system, let me underline the importance of the family in providing care—spouse, son, or daughter, even a caring neighbor. That is the first line of defense, and a long-term care policy and reimbursement scheme should incorporate ways to build this foundation. Of course, I am speaking of those who are fortunate enough to live in a family or among caring friends. A long-term care policy should enable caregivers to purchase needed services from providers within the community.

Second, there is within most communities a growing number of services designed to provide respite to a caring family, including therapeutic services, transportation, adult day care programs, senior centers, hospice programs, friendly visitors, and other community-based voluntary organizations and efforts; churches, social organizations, neighborhoods, and various coalitions deliver a variety of services that often enable one to remain in the community. An insurance program should direct resources to strengthen these low-cost, but essential, services.

Third, home health care services are a key part of the long-term care system; and these services must be covered.

Finally, there is the nursing home aspect, including, some acute care in the long-term care system. This is, of course, the element which has everybody's attention because care in these settings is expensive. The number of persons requiring this level of care is high and rising; an insurance policy must assuredly cover these high costs.

While I have been speaking of insurance, I have not limited my use of the term to private insurance. Medicare and Medicaid are insurance programs, vehicles for society to deliver to people in need essential, health-related services. Because of aggregate costs, these programs have come under tough questioning. Sufficient attention to what may be needed to broaden these programs, improve benefits, and deliver services is largely absent. The compelling cost picture seems to force us to the balance sheet, the bottom line, and despair.

Our formal testimony offers three principal points, and I just want to hit them quickly.

Medicare and Medicaid are the fundamental and critically necessary programs helping to provide for health care needs of America's elderly and providing the support families need in that process. Medicare and Medicaid need strengthening to provide for the total health care needs of all older Americans.

Second, long-term care must be viewed as a continuum of health and social services ranging from those provided in institutional settings to those provided through community-based programs to those provided in an individual's own home. We believe both Federal programs and private insurance must cover services such as adult day care, home health, respite care, and homemaker assistance, because these services are often best suited to meeting the care needs of an elderly person while allowing that person to remain in the supportive and familiar environment.

Further, community-based, long-term care has distinctive differences from the components of the health care system covered by Medicare in that social services often play a larger role than health services. However, it is an integral part of the overall continuum of care, and should be financed by the Social Security System. This could be achieved through a separate title of the Social Security Act, a title XXI, or by an expansion of Medicare. Medicaid, a program for the poor, should not continue as the principal public response to the urgent and increasing need for community long-term care.

Third, new initiatives such as long-term care insurance represent an interesting approach in helping to meet the cost of care for older persons. But in no way should private long-term care insurance be considered a substitute for coverage currently provided under Medicare and Medicaid or for the needed new Federal coverage.

Moreover, while private long-term care insurance can play an increasingly significant role in helping to cover services not currently covered under Federal and State programs, the cost of such private coverage must be spread among the universe of persons participating in a particular group health insurance plan so that the costs does not become prohibitive.

I will close by saying that the National Council on the Aging is eager to work with you, especially in the context of something that might be called independent living insurance—as opposed to the variety of the health-related ways we define what is needed—because we are convinced as an organization working for, training, and representing the service providers which deliver services to hundreds of thousands of older people, that it is in the context of community-based, supportive arrangements, that long-term care systems need the greatest amount of support. I would suggest that within the community-based part of the long-term care system we will get the largest return on public investment, because it will build on a huge base of private investment and private initiative.

Chairman HEINZ. Mr. Sykes, thank you very much. Without objection, your entire statement will be made a part of the record at this time.

[The prepared statement of Mr. Sykes follows:]

PREPARED STATEMENT OF JAMES T. SYKES

The National Council on the Aging, Mr. Chairman, appreciates the opportunity to share it's perspectives with the committee as to how our Nation can best meet the long-term care needs of the elderly. We commend the committee for organizing this hearing and stand ready to work with you to develop appropriate legislative approaches to meeting the critical challenges involved in the delivery and financing of comprehensive long-term care services.

My name is James Sykes, chairman of the NCOA's Public Policy Committee. I currently serve, in addition, as director of public service of the Wisconsin Cheeseman—and I am a former member of the Presidentially-appointed Federal Council on Aging.

The National Council on the Aging has been working to improve the quality of life for older persons since 1950. Our organization has played an important advocacy role in promoting public policy changes to provide vital assistance to the elderly. And, at the same time, our organization and its affiliates have developed and operated important innovative programs which directly affect the daily lives of hundreds of thousands of older people. These programs include senior centers, adult day care, employment and training, housing, and social and support services.

Our testimony will examine various aspects of the topics which this hearing is intended to explore. But there are three principal points we wish to express to you today.

(1) Medicare and Medicaid are the fundamental and critically necessary programs helping to provide for the health care needs of America's elderly. Due to uncontrolled health care cost escalation and ill-advised program reductions, these vital programs are failing to provide the comprehensive assistance to older persons for which they were designed. Medicare and Medicaid need strengthening to better provide for the total health care needs of all older Americans.

(2) Long-term care must be viewed as a continum of health and social services ranging from these provided in institutional settings to those provided in community-based facilities to those provided in an individual's own home. We believe both Federal programs and private insurance must cover services such as adult day care, home health, respite care, and homemaker assistance, among others, because these services are often best suited to meeting the care needs of an elderly person while allowing that person to remain in the supportive and familiar environment of this or her own home. Further, community-based long-term care has distinctive differences from the components of the health care system covered by Medicare in that, in most cases, social services play a larger role than health services. However, it is an integral part of the overall continuum of care, and should therefore be financed by the Social Security System. This could be achieved through a separate title of the Social Security Act (a title XXI), or by an expansion of Medicare. Medicaid, a program for the poor, should not continue as the only public response to the urgent and increasing needs for community long-term care.

(3) New initiatives such as long-term care insurance represent an interesting approach to helping to meet the cost of care for older persons. But in no way should private long-term care insurance be considered a substitute for coverage currently provided under Medicare and Medicaid or for the needed new Federal coverage. Moreover, while private long-term care insurance can play an increasingly significant role in helping to cover services not currently covered under Federal and State programs, we believe the costs of such private coverage must be spread among the universe of persons participating in a particular group health insurance plan so that the costs do not become prohibitive.

The NCOA believes that the Congress must examine the topic of this committee hearing in the context of improving our Nation's overall health care system serving older Americans. Tragically, the current system falls short of ensuring assessible, affordable care for older persons at levels most appropriate to their needs. The NCOA calls on this committee to play a leadership role in the development and implementation of: a more responsive and effective health care delivery system, cost containment that improves quality of care, restoration of reductions in Medicare and Medicaid benefits enacted in recent years, genuine catastrophic illness coverage under Medicare, and long-term care options in comprehensive, coordinated, community-based service systems.

HEALTH CARE DELIVERY SYSTEM

The Nation's health delivery system is deficient in ways directly detrimental to present and future older Americans.

More than 25 million persons—including 4.5 million women aged 45 to 64—have no health insurance of any kind.

The quality of care throughout the Nation is uneven, and for many older persons access in difficult. Primary care providers are "virtually nonexistent," according to the National Health Law Project, for nearly 20 million people living in rural areas and deteriorating neighborhoods.

The misguided reimbursement policies of Medicare, Medicaid, and private insurance result in an overemphasis on medical care for older persons and institutionalization, when more humane social services, community nursing and community-based long-term care would be more effective in maintaining many older persons in their home environment.

For those who require nursing home or board and care placement, the choices are often limited to substandard or too-costly institutions.

There is evidence that minority group members experience especially harsh access problems that are likely to contribute to deterioration of health.

Most physicians are products of medical schools that give scant geriatric training, and many physicians may harbor negative attitudes toward older patients in need of steady support rather than specialized treatment.

HEALTH COSTS MUST BE CONTROLLED, QUALITY UPGRADED

Health care costs have risen from $49 billion in 1967 to $322 billion in 1982. In 1982, the national health bill included: Hospitals, $136 billion; physicians, $62 billion; nursing homes, $27 billion; drugs and medical sundries, $22.4 billion. The costs are already staggering, and still going up faster than the average cost of living.

Based on current trends, national health expenditures could reach $756 billion in 1990 and consume roughly 12 percent of the gross national product. The cost question will not solve itself; it cries out for far-reaching corrective action.

The first significant national response thus far changes reimbursement procedures in Medicare. This prospective reimbursement approach does not deal with physician fees, which are a major cost element in hospital stays. It also risks the shifting of costs from Medicare patients to "private-pay" patients, and discrimination against Medicare patient because of the reimbursement limitations.

Hospital administrators, struggling to comply with the complicated diagnosis-related groups (DRG's) on which the system is based, may be tempted to select patients on the basis of DRG reimbursement requirements rather than on the actual needs of the patients. Continuity and quality of care could suffer, unless enlightened hospital directors and physicians resist negative incentives contained in the prospective payment system.

NCOA Recommendations

Legislation to extend the prospective payment system to cover all patients.

Extension of the prospective payment system to doctor fees connected with hospitalization and mandatory acceptance by physicians of Medicare reimbursement fees.

Introduction of quality care incentives into the prospective payment system.

MEDICARE REQUIRES STRENGTHENING

Medicare has brought immense gains in access to health care for older Americans. Before 1965, only 68 percent of the 65-plus population saw a physician once a year; now, 83 percent do. Well over 90 percent of Medicare participants have a regular source of medical care. Such improvements have undoubtedly contributed to the declines in the death rate for heart diseases and strokes within recent years.

Medicare, however, is often erroneously portrayed as a threat to the Nation's budget and a candidate for early bankruptcy because of the rise in the number of elders it serves and because it seeks to do too much for them.

Actually, Medicare's problems spring in large part from fundamental flaws in the Nation's health care system. Far from being overly protected, Medicare participants:

Pay at least as high a proportion of their income today for care as they did before Medicare became law.

Face new increases in the amounts they must pay to receive Medicare's limited coverage.

Medicare, the central element in health care for older Americans, needs major reform. But current plans aimed at cost-shifting and cost containment do not aim at reform. They promise little more than heavier burdens on those most in need of help. Copayments, for example, are a direct charge on those unfortunate enough to fall ill; increased copayments would be particularly onerous on low-income Medicare participants, who pay a greater proportion of their income for copayments than those with higher incomes.

NCOA Recommendations

Resist new attempts to increase copayments and deductibles under the hospital and medical parts and premiums under its medical part. (Medicare participants, now pay out-of-pocket expenditures totaling $1,500, a 122-percent increase within 6 years.)

Refuse to impose a means test on Medicare recipients.

Reject proposals to establish a voucher system to supplement Medicare as unrealistic on several grounds: (1) "Shopping" for health insurance in the private market would be difficult for many older Americans; (2) elders who opt to remain in Medicare would probably be those most in the need of treatment; (3) Medicare's base of support would be diminished at a time when it should be broadened.

Maintain a freeze on physician fee levels and require physicians to accept Medicare's assigned fee levels.

Expand Medicare coverage to include comprehensive in-home and day care services, health maintenance services, hearing aids, eyeglasses, most prescription drugs, foot care and most dental work.

Provide incentives for States to establish statewide health care plans, under Federal guidelines, to meet national cost reduction standards while meeting individual State needs and priorities.

Provide positive incentives for enrollment of Medicare beneficiaries in health maintenance organizations (HMO's) and increase Federal support for development of HMO's. In addition, NCOA believes that full Medicare coverage for social health maintenance organizations (SHMO's), which are intended to provide a complete range of social and health services, should be considered at an early date in the interests of cost effectiveness and increased support for genuinely comprehensive community-based care/support systems.

Maintain a close watch over so-called private "medi-gap" insurance sold to supplement Medicare coverage.

CATASTROPHIC ILLNESS PROTECTION

Medicare's hospital cost protection does not cover stays extending past 60 days. This limitation raises the specter of financial ruin for older persons (and their offspring) in the number of instances in which hospitalization is required for far longer periods.

In 1983, an administration proposal would have reduced costs for a typical 6-month illness from an estimated $19,000 to $1,580 for the elderly Medicare beneficiary. The price of this, however, would have been a major increase in "cost-sharing" required for all other Medicare participants. This proposal would have helped very few individuals, since less than 0.05 percent of beneficiaries ever use all 60 days of their Medicare hospital benefits. The increase in coverage for such a benefit would be more than offset by increased coinsurance and deductible charges to all Medicare hospital users.

One example of the consequences of the administration proposal, provided in a study devoted to arthritis policy (15 million older Americans have some form of that disease), shows that elderly persons with chronic illnesses generally require more frequent but shorter hospitalizations than persons with an acute, catastrophic illness. They would suffer severe consequences under the proposal.

NCOA Recommendations

Congress design a catastrophic hospital coverage feature under Medicare that would not be a tradeoff with cost-sharing requirements made on all persons who receive hospital benefits under that program. Catastrophic coverage should be considered on its own merits and not as a part of a package deal.

MEDICAID—THE POOR NEED COVERAGE, NOT CUTS

Medicaid is a program limited to low-income persons of all ages. It now serves about 3.4 million elderly persons. Nursing home care is key Medicaid service for older persons, since Medicare does not cover long-term care. At least $7 billion of the $11.3 billion spent under Medicaid for nursing home care in 1981 was for older persons.

A caring Nation cannot justify the simultaneous reduction of taxes for the more affluent members of our society while economizing by placing needed health care out of the reach of those who cannot pay for it. Further, Americans who are poor should not be penalized because of where they live. We must move toward a uniform set of services available in every State.

To improve the Medicaid program, States should remove barriers and improve benefits for those who must rely on its provisions for their health.

NCOA Recommendations

Remove limitations on the amount, duration, or scope of medical services that were imposed to save money rather than to meet the health needs of the medically indigent.

Reject imposition of copayments that restrict eligibility and increase burdens for the poor of all ages.

Refuse to require families of patients in nursing homes to pay part of the charges under Medicaid because such efforts are unworkable and unfair to individual family members who may already have borne much of the brunt of caregiving before institutionalization became necessary.

Reject proposals to reduce the Federal share of Medicaid and seek full restoration of the original Federal share.

Provide mandated services to all persons whose incomes are below 125 percent of the poverty line.

Offer additional services important to individuals that prevent or lessen the pain and suffering of ill health.

Explore ways to reduce institutional costs by making noninstitutional care more available and provide community-based, responsive care and support alternatives for older persons. The capacity of senior centers and adult day care programs to provide a holistic approach to individuals should receive special attention.

THE ENTIRE COMMUNITY MUST PROVIDE LONG-TERM CARE

Chronic illness now exceeds acute illness in the United States in terms of the number of persons affected. This major change has not yet received an appropriate response by most health care providers. The high-cost, medical model of care (that depends on techniques more suitable to acute illness rather than long-term illness) is more the rule than the exception.

As summarized by the Senate Finance Committee: In 1982, approximately $13 billion was paid out through the Medicaid program for institutional long-term care services. Public expenditures have historically followed an expensive medically oriented approach to long-term care in spite of the fact that many impaired individuals are institutionalized because of a lack of nonmedical community-based support services that assist them in maintaining an independent existence.

Increasing attention has been paid to the development of cost-effective home- and community-based delivery systems, but difficulties in coordination among the services grouped under the "health," "mental health," and "social services" labels have been formidable. This has significant consequences for government programs and private payors. It also has far-reaching consequences for the older persons and others thus affected.

Another factor with as yet unknown consequences is the growth of large-scale chains of profitmaking nursing homes and in-home service providers.

The chronic health problems of millions of older Americans in this Nation require new approaches if the rapidly growing number of vulnerable older persons is to be cared for properly. The institutional answer is not always acceptable even though for many individuals a nursing home may represent the most appropriate level of care.

NCOA Recommendations

Help (including in-home services, respite and tax deductions) should be made available to families attempting to provide such support.

Assessment and case management services—to assess the needs of persons requiring long-term care and to arrange for the appropriate array of services and support—and adult day care should be specifically identified as eligbile for reimbursement under title III of the Older Americans Act.

High-quality institutional care should be provided to persons for whom no other care or support is appropriate, and this care should be made available under a Federal-State regulatory structure abiding by the following principles:

(1) The regulatory system shall ensure that all residents of nursing homes receive quality care in a safe environment that promotes a positive quality of life.

(2) The government shall budget sufficient monies to reimburse facilities to provide such services and to ensure that state survey agencies maintain a strong survey and enforcement program.

(3) The government shall monitor the system to ensure that tax dollars are spent appropriately, and that providers are accountable to the public for such expenditures.

Congress should closely monitor a Veterans Administration program providing community-based long-term care services, in order to adopt and apply models deemed successful by the VA.

Adults day care programs should be recognized as a vital part of the total long-term care system and be available and accessible for functionally impaired adults.

Multipurpose senior centers, as focal points for the actual delivery of health, social, nutritional, educational, and recreation services required by chronically ill or disabled older persons, be recognized as key components in community care/support networks.

RECOGNIZING AND MEETING OLDER PERSONS' NEEDS ALONG THE CONTINUUM OF CARE

In a recent report on the social and economic impacts of the graying of America, the Health Insurance Association of America concluded: "Financial protection against the costs of long-term care may well become the dominant financing issue in the coming decade."

The National Council on the Aging concurs in HIAA's projection. But we are concerned with the traditional, limited perception of long-term care solely as these services provided in nursing homes. Nursing homes certainly represent a fundamental component of any community's long-term care continuum—but they are only one component, notwithstanding their almost exclusive historical relationship to existing financing mechanisms. For older people and their families to find adequate and appropriate long-term care responses to chronic care needs, a much wider range of services needs to be made available and financed as part of a true long-term care system.

The Health Insurance Association of America (HIAA) has recognized the breadth of scope of LTC services by defining long-term care as:

"A complex and interrelated array of health, health related, and social services designated to provide preventive, therapeutic, rehabilitative, supportive and maintenance care for individuals of all ages who have chronic physical and/or mental conditions which impair the individual's ability to function as his or her own optimum level of mental, physical and social functioning."

The services identified by HIA as essential elements comprising long-term care include, in addition to "traditional" medical care services:

Homemaker services—cooking, shopping, laundry, home management.

Chore services—less frequent tasks related to home maintenance.

Social services—guidance concerning social or emotional problems, advice on financial or legal matters, transportation.

Health related services: (1) Nutrition and health education; (2) personal care services: bathing, toileting, feeding, assistance with walking, exercise, medication; (3) occupational therapy: medically-directed activities to promote the restoration of useful functioning.

Skilled services: (1) Physical and speech therapy: use of physical or chemical agents and devices to relieve pain, restore functioning, and prevent loss of use of part of the body; (2) skilled nursing: administration of medicine, changing of catheter and dressing, evaluation of condition.

Housing services—provision for continued housing allowances for those undergoing extensive in-patient rehabilitation; group or congregate living arrangements, including social care and dining and service facilities.

Also critical are such services as: assessment, case management, and service coordination.

These services are offered or assessed through a wide array of community based service agencies. They include home care and day care agencies, senior centers and family service agencies, and many other types of organizations that may offer a single service such as a home delivered meal or that may access and coordinate the entire array of services such as the "channeling" agencies that are part of the ASPE/AoA demonstrations.

Researchers have established that an individual becomes part of the long term care population not as a result of a particular diagnosis or condition, but from the need for supportive services over a period of time. As Scanlon and Feder note in a recent issue of Healthcare Financial Management, "More likely than not, the services are nonmedical rather than medical, and unskilled rather than skilled. Most prominent among them are personal care * * * mobility assistance * * * household assistance * * * and supervision."

Carolyne Davis, Administrator of the Health Care Financing Administration (HCFA) in addressing a recent HCFA conference, both acknowledged that most aged persons with functional limitations prefer to remain in the community as long as possible and underscored the need for responses that move away from the traditional institutional approach and toward caring for the needs of the elderly in the community. Many States are now experimenting with home and community-based delivery systems for frail and disabled individuals. But they are only experimenting—the numbers participating are relatively few. And the States seem reluctant to expand the numbers. Indeed, State Medicaid program administrators are reluctant to add to the already burgeoning costs involved in meeting Medicaid obligations for nursing home care. This provides clear evidence of how high nursing home costs are stymieing the development of community based-services acknowledged to be needed by older persons.

Our Nation carries out a cruel hoax on older people. When they truly need chronic, long-term care, they either have to be wealthy enough to afford scores of thousands of dollars a year—or must improverish themselves—to be able to access the primary long-term care "system" available, the nursing home. To be Medicaid-eligible for nursing home services, if the frail older has a spouse, that spouse too must be impoverished and yet still somehow try to maintain himself or herself in the community. And, moreover, once institutionalized for any significant period of time, the older person usually has lost the financial capacity to return to the community. Informal as well as formal supports are also likely to be unavailable or inadequate.

The National Council on the Aging believes that a good part of the dilemma facing our country today with regard to the burgeoning costs of long-term care—driven by what Ann Somers refers to as the "gerontological imperative"—is the result of the almost exclusive focus on reimbursement for institutional care (nursing homes) to the exclusion of services provided in alternative settings which might in fact be more appropriate for chronic care needs. Not everyone in nursing homes needs the full range of care provided, but there are few reimbursed alternatives available to enable frail older persons to remain in the community.

Much research confirms that the supports generally needed by frail older persons to maintain their physical, psychological and social well-being are of a hybrid social-health nature. Marjorie Cantor, president of the Gerontological Society of America, identifies three major needs: (1) Socialization and personal development; (2) the carrying out of daily living tasks such as meal preparation, shopping cleaning and laundry; and (3) personal assistance during time of crisis or illness.

We know that older people perceive their informal network of family (particularly spouse and children), friends, and neighbors as the most appropriate source of support, and research has shown that the informal network indeed provides most of the necessary support. Family, friends, and neighbors are ready, willing and able to be responsive to the needs of the elderly in their midst. But the responsiveness has limits, and the willingness wanes when days turn into months and then years. Cantor recently reported on a study that showed that the overriding problem for all types of caregivers—spouse, children and friends—was the emotional impact of dealing with increased frailty in a person with whom one is close. Caregivers, mainly wives, daughters and daughters-in-law, are extending themselves to cover all their varied roles and any personal time is sacrificed under relentless time and energy restraints. As women join the work force in ever increasing numbers, the stress and strain upon them will intensify. What about the physical and psychological toll on the individual caregiver? Many of these individuals are themselves old and some are frail. Also there are at least one third of the elderly who have no children or none living nearby. For all of these people, in-home, adult day care and other caring and respite-type services are needed and necessary. Yet they are all-to-often not available or not affordable.

A great deal of study has been directed to in-home services and their role and value in a cost-effective and humane system of care. NCOA is concerned, however, that too little attention has been directed to other components of community-based care. We believe that every community should be able to put into place for its older citizens a comprehensive system of coordinated long-term care services. These systems should be comprised of a range of care options to support the older person and supplement the assistance provided by family and other informal caregivers, and by formally-organized community agencies and institutions. We strongly believe that only a system that supports both informal and formal services and maintains the balance between them will result in cost-effective and humane care. Both the public and private sectors have a role to play in financing and ensuring the quality of these long-term care systems.

NCOA believes that group-oriented services such as adult day care have not been adequately supported as part of long-term care services. Yet adult care programs are increasingly serving those with dementia, incontinence and loss of mobility—the three factors which create the heaviest burden on caregivers and eventually lead to nursing home placement.

While the adult day care field has grown from a dozen programs in 1969 to more than 1,000 programs today, NCOA's National Institute on Adult Daycare (NIAD) considers the field only to be in its adolescence. The availability of adult day care is still very limited, existing programs are small, further development has been hampered by the lack of understanding of services and by the scarcity of third party reimbursement and the constant struggle which local programs face to maintain funding.

Several studies have shown adult day care to be a critical and unique component in the community's care continuum. Adult day care is also becoming increasingly important as a cost containment mechanism. Not only does adult day care save money for those footing the care bill, but outcome measures show improvement in maintenance of functional ability, thus delaying or avoiding more costly institutionalization.

Capitman's evaluation of California's adult day health care program in 1982 shows that:

(1) Adult day care serves clients who are certifiable at the SNF or ICF level or at risk as determined by the State.

(2) The adult day care population is similar in functional ability to the SNF population (the more incapacitated group).

(3) The average adult day care participant's total monthly costs (including all public sector costs—adult day health care, other medical in-home services, SSI and the State supplement) as compared to SNF/ICF resident costs saves the State $3,180 per person per year.

(4) Between 87 and 96 percent of adult day care participants with multiple, severe impairments maintained or improved their level of functioning while in adult day care.

A 2-year study in New Jersey released in 1980 which evaluated the functional disabilities and costs of adult day care participants provided similar conclusions. The adult day care population in New Jersey was also found to be one which would largely have been institutionalized if it were not for the adult day care programs. The study found that adult day care cost New Jersey and the Federal Government $4,218 less per person than nursing home costs would have been for this population. Furthermore, reports from family members make clear that adult care is critical to their maintaining their loved ones in the community. Aside from the program's ability to increase or maintain a participant's functional capacity, family members were grateful for the respite that adult day care provided them from the constancy of caring.

In the words of the spouse of an adult day care participant in her early eighties who suffer from multiple medical problems, both socially and physically: "My wife has been coming here since July of last year. Not only has she benefited, so have I * * * I know she is safe here. That gives me some free time for myself. It's been helpful."

The conclusions of these studies and other studies underscore that adult day care is, indeed, a true alternative source of care and a cost-effective one. The NCOA believes the data makes a compelling case for vigorous Federal support for this vital program and other community-based long-term care services.

Adult day care is just one example of an existing service delivery model at the community level that is appropriately responsive to the needs of older people in a cost effective way. Other essential levels of a comprehensive long-term care system which meets the needs of older persons have also proven their value—senior centers and comprehensive nutrition programs, congregate housing, etc.—but not all such responses have been integrated into an accessible, affordable system of long-term care.

Health and social programs won't have the opportunity to fulfill either their human or fiscal potential until they are fully recognized as eligible for reimbursement under Federal programs or by third-party players under private health insurance.

NCOA joins those who recognized that new approaches must be explored to finance the delivery of a true continuum of long-term care and that private insurance may represent a viable option to expand coverage for noninstitutional services in particular. Whether private coverage is to apply to either institutional or noninstitutional services, however, we believe that the costs of providing such coverage should appropriately be spread among all participants in a group health plan. Our Nation's sad experience with so-called "med-gap" supplemental Medicare insurance—from exorbitant premiums to policies of limited-value or duplicative coverage—argues for provision of long-term insurance coverage as an integrated part of the basic group health plan rather than as an item to be marked on an individual basis.

We also have some doubt as to the economic feasibility of LTC insurance exclusively supported by premiums paid by elderly policyholders. But we have no doubt whatsoever that equity demands that this vital coverage be required as just fundamental a benefit as a basic health plan might provide for the breaking of an arm or the birth of a child.

The only real difference which distinguishes an expansive LTC private health insurance benefit from those examples is that chances are it will be utilized later in life if at all. Private LTC coverage should be funded through very modest premium increases assessed across the entire universe of plan participants throughout the years they have made contributions or had contributions made on their behalf to the plan; they should in turn be eligible for the LTC benefit if and when it is required, whether or not that may occur in pre- or post-retirement.

The NCOA commends you, Mr. Chairman, for calling this hearing, and we hope our insights will prove to be helpful to you and your colleagues as you study the important questions relating to the continuum of long-term care services and how such services can best be developed and financed through government, private corporations, and nonprofit agencies. We look forward to continuing to work with this committee to define solutions to the crucial problems this hearing is examining.

And similarly, continuing our tradition of working with the private sector, NCOA is already working with elements of the insurance industry to further develop the concept of long-term care insurance.

Chairman Heinz. Let me ask a question of Nancy Versnick and Bob Bennedict and Larry Lane. In the survey that was done by the American Health Care Association regarding the kinds of insurance available, you noted that private long-term care insurance coverage is available, affordable, expanding, and adequate.

I would like to focus in on the word "adequate." We have received a lot of testimony, not only today, but on many other occasions, that what is most needed is home health services. Most people want to stay out of nursing homes. To what extent do these policies, provided by some over 25 insurance companies, provide anything in the way of home health care services to keep people out of nursing homes?

Larry, I guess you are the expert in this area.

Mr. Lane. Thank you, Senator Heinz. Basically, the policies that are on the market now do not expand coverage into the home care area, with one or two policies offering rider coverage that may cover home care.

I think the issue of adequacy as we were looking at it was an issue of does an indemnity payment provide a sufficient payment for per diem coverage in order that an individual could secure quality service. In that context, an indemnity payment of in the range of $30 to $40 per day, in addition to a cost index/Social Security payment would be sufficient to pay for skilled care.

I am happy to say in home care benefit, though, that there is a second generation of policies that are being developed. I will submit for the record a memorandum [1] that we have been using, attempting to stimulate insurance companies to offer not only a nursing home coverage, but also a home care coverage. The memorandum suggests three basic options—discharge to home care, discharge to nursing home, or a flow through nursing home to home care.

We are finding some companies interested in expanding from a nursing home to a home care coverage. We are finding very little interest because of the concerns of induced utilization of hospital to home care. We are working with the National Association of Home Care in a joint effort on this.

I also would like to submit for the record a paper entitled, "Private Insurance for Long Term Care: Availability, Problems and Actions."

Chairman Heinz. Without objection, so ordered.[2]

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[1] See app. 1, item 1.
[2] See app. 1, item 2.

Well, I asked the question because, were someone to pick up the testimony and read the last word, "adequate," without the explanation that you have just given, they would come, I fear, as Americans have been coming for some time, to the wrong conclusion—that there is light at the end of the tunnel. Right now, there is no light at the end of the tunnel. And what you are saying is, yes, there are some policies out there that cover skilled nursing care or intermediate care. But for other services and costs—companion/home health aide, $5 to $8 an hour, adult day care, $22 to $25 per day, licensed practical nurses, $15.50 per hour, registered nurse, $43 per visit—there is no insurance out there right now. So in your report, I guess I would just have added a fifth category, which I would term, "Responsiveness to desires of elderly" and that would, I think, have made a slightly more complete presentation. I do not say this to be critical, but just to make sure that no one thinks that all we have to do is just do nothing, and the problem will go away.

Mr. LANE. Every study has a focus, and our study was looking at the coverage for nursing home care. We were looking at licensed facility care. And, given that nursing home care is the No. 1 catastrophic expense, and that the probability of having that expense occur is much greater, actuarially, than is perceived by the general public, that expense is what we were looking at, primarily.

Chairman HEINZ. Let me ask Bob Bennedict—we Pennsylvanians have to stick together, you know—Bob, in your experience in Pennsylvania, do you know of any long-term insurance policies that are available in our State?

Mr. BENNEDICT. There are two or three, but I think it reflects the national trend, that they were built primarily off of medi-gap, with slow and cautious experimentation around the margins.

Chairman HEINZ. So they do not cover much in the way of home- or community-based care.

Mr. BENNEDICT. Not to my knowledge. In fact, Larry could probably better answer that. He has done more of an analysis of individual policies than we have.

With regard to the light at the end of the tunnel, perhaps it should be rephrased, that there is at least a glimmer at the front end of the tunnel. For the last 15 or 20 years, we have focused so exclusively on Medicare and Medicaid, particularly Medicaid in providing long-term care, and it is obvious that State and Federal governments are simply not in a position or inclined to pick up the burden that is there. So, having the Congress, having the private sector, beginning to express an interest in other ways of getting this job done is a glimmer of hope that we all have to track down.

Chairman HEINZ. Well, it may even be more serious than that. I am worried that most people, even today, notwithstanding this and other hearings like it, both present and future, do not know they are in a tunnel, as evidenced by the AARP survey. Does anybody disagree with my concern that there are an awful lot of people out there who do not realize, as I think the previous panel illustrated pretty clearly, that they in fact are in a tunnel, and there is not only no light, but there is no exit. And, if you have read Albert Camus, you would know that is not a great position for anyone to be in.

Let me ask what I suppose would be a health policy question of Nancy Versnick. If the private long-term care insurance market were stimulated through these policies—let us suppose the one that you described in your testimony did become broadly available—is there any risk that private pay patients would be occupying more nursing home beds and crowding out Medicaid patients?

Ms. **Versnick**. I have to speak from Kentucky, because that is where I have been in long-term care for over 20 years. Presently, in Kentucky—I think my figures are correct—80 to 85 percent of the people in nursing homes are on Medicaid. I do not see a crowding out.

Right now, you do not have an alternative, Senator. You either go in as a private pay and spend down to a Medicaid recipient, or you are Medicaid before you go in. You just do not have an alternative.

Chairman **Heinz**. Let me ask you a statistical question with respect to Pennsylvania, Bob Bennedict, or Kentucky, Nancy Versnick. Do we know the number and percent of people now in nursing homes in those two States that entered as private-paying patients? And can you get that information for our hearing record, if it is available?

Ms. **Versnick**. I think we could.

Chairman **Heinz**. We would appreciate that. It would be very helpful in identifying what is really going on.

In Kentucky or Pennsylvania, isn't there already a problem of too few nursing home beds for Medicaid patients? Is that a problem?

Ms. **Versnick**. Too few for any patients. We have been under a moratorium for over 4 years.

Chairman **Heinz**. Bob, in Pennsylvania?

Mr. **Bennedict**. Yes; Pennsylvania is, I think, the second most elderly population State in the country with regard to proportion. The State ranks 34th or 35th with regard to nursing home beds per thousand.

The State health department has recently estimated that at the minimum, we need today about 5,000 new nursing home beds in the State of Pennsylvania, and we also are living under a moratorium in Pennsylvania.

Chairman **Heinz**. Let me ask Betty Houchen, Ms. Houchen, there is some concern that services are not appropriately targeted—that is, the services that people get are not necessarily the services people need. With insurance, how could we improve our effort to target services to people that need them—or are we likely to have it go the other way?

Ms. **Houchen**. With insurance coverage, there would be payment for the services that these people need in the community. Right now, there is no payment available for agencies trying to provide the services. So, if the patient is not eligible or not covered by Medicare or private insurance, there just is no payment available, and patients either receive limited benefits—we as a public agency do provide services that are supported by city general fund money, so we can provide some of these services to the indigent or for those who have no third party reimbursement. But that is very limited, and there are many other types of community services that do not have that funding support to do that.

Chairman HEINZ. If we were successful in doing what we have been talking about today, do you think that independent living insurance, long-term care insurance—call it what you will—would diminish the role of families, who now give most of the care, and increase the reliance on paid caregivers?

Ms. HOUCHEN. No, I do not believe so. I believe that the majority of the families who are able to care for their parents or the members of the family who need the help would continue that, but——

Chairman HEINZ. How can you be so sure?

Ms. HOUCHEN. I think they are committed to having that person remain at home. And the people we see, we work with the families; we do not substitute for the families. That is one of our criteria for service, that we take that family to take care of the person in the home. We provide supportive services so that person is able to keep the patient in the home.

And my feeling is the majority of people we see want to do what they can, but they, by their own physical conditions are limited—which we heard from the previous panel. The couple I cited, who are in their nineties, by reason of age, are limited in what they can do. But the families we see do do what they can, and we provide only supportive services to supplement that.

Chairman HEINZ. And yet, of course, we all know that there are not enough services available—home health aides, licensed practical nurses, registered nurses—on an outpatient basis. Why wouldn't insurance cause more utilization of those services I just mentioned?

Ms. HOUCHEN. I believe you would see more utilization, but it would be because the need is there and not being met now.

Chairman HEINZ. It would not be a replace of care given?

Ms. HOUCHEN. No.

Chairman HEINZ. We do not have respite care—well, I suppose you could look at adult day care as respite. My feeling is—and this is not an argument against having long-term care insurance—but that there probably is going to be more utilization of what I might call respite care. I think we have an awful lot of families who get stretched to the breaking point and need a break.

Ms. HOUCHEN. Yes.

Chairman HEINZ. So—I am not an expert, and you are, but that would be my best guess.

Ms. HOUCHEN. One point on respite care is that on companion or home health aide, I think you could look at that as a type of respite care, too. Our home health aides, as we are able, will remain in the home for many hours at a time to provide the caregiver time to get out.

Chairman HEINZ. Jim Sykes, one of the things you mentioned in your statement is that you feel that our Nation's sad experience with so-called medi-gap, supplemental medical insurance, argues for provision of long-term care insurance as part of an integrated, basic group health plan, overall, rather than market it on an individual basis. You have two thoughts there.

One, I gather you feel that medi-gap insurance has been much more a bust than a boon; is that correct

Mr. **Sykes**. That is correct.

Chairman **Heinz**. Should Congress find a way to preempt the medi-gap insurance market? Should we provide under Medicare, the kind of so-called catastrophic coverage that often is a part of medi-gap insurance? Most people say that that is a pretty profitable part of those insurance policies. If we include it under Medicare, it would not cost the Government a lot; we could probably find a way to make that up. I happen to favor doubling the excise tax on cigarettes, and I have a bill in—MIRA, the Medicare Incentives Reform Act of 1984—that does what I just described.

Is that a good idea, to preempt medi-gap policies as I have described, so that people begin to understand that maybe the gap in medi-gap isn't much bigger, or a much wider chasm than they ever realized?

Mr. **Skyes**. Senater, I think the essential problem that we have in the national discussion in this area comes around gap filling. The insurance discussion has to do with what are the exposures, what are the risks, and how do we cover for them. There is an assumption that there is a set of discrete risks and exposures, and for each of these, we must provide some kind of coverage.

What I have argued here today is that we must really move as a society to long-term care as a system-building concept as opposed to gap filling. Every one of the efforts to fill a gap will have all kinds of problems because it appears to presume that somehow, what one needs at a particular time is a discrete service, and one can find it if one has a case manager, if there is a program. You need exceptional people to be sure that at the moment in one's life for which there is a gap to be filled, there is somebody who can help one fill it.

What I have tried to suggest, in a way that I think is consistent with some other national policies in our world, is that if we approach long-term care insurance as a gap filling or as a problem-solving device instead of a community system-building one, we will always come up short.

And what I have argued is that within a community setting, for example, while we may be able to pay for the physical therapy somebody needs, that same physical therapist, in the community, will be able to help another five or six people in the preventive area, with help that they need but for which there is no reimbursement.

So my concern is to see how many ways we can help build essential community components of the long-term care system, rather than filling gaps. The first one has to do with the family, like respite care, and all the ways families can be helped—at little or no cost—to provide essential care for the family member in need. And the extent to which we deliver services in a community, either home health services directly to one in her home or through community facilities and programs, such as I have in Sun Prairie, WI, we are not only going to care for that one specifically at the moment she needs help, but we will be developing a caring community that is, in effect, the best insurance policy we can have. Efforts to define losses, set premiums, pay for discrete services are misguided, in my judgment.

Chairman HEINZ. You touched on this subject indirectly just now, and in your testimony. It is really touched on whenever people use the term, "continuum of care." There is a dichotomy we do not often recognize between the medical model of providing care and the social model. Medicare, medi-gap, Medicaid policies are based on this medical model: "You are sick, and we are going to fix it." It is the old American syndrome of, you see a problem, and you solve it. And that is the medical model. The best practitioner of that is a surgeon. He looks at you, he says there is nothing wrong. The next day, he has opened you up and sewed you back together. That is American "can-do".

Why are so many of our policies and programs tied to the medical model, when we know that it is really, I suspect, most often the social services model that helps people to recover the most?

The best example was our witness from Pennsylvania, Ella Thomas. A lot of her problems could have been helped—not solved, but helped—if she got a little advice, not surgery.

Mr. SYKES. Well, strangely enough, we have inherited a system that actually had some pretty good bases. Back in the communities years ago, the doctor was the one who knew the patient, understood the family and the circumstances. And when that person came to him with some kind of a particular problem, that doctor was in the position not only to do a physical diagnosis, but he was also able to see that person in a social context.

But, as we look for ways to administer programs effectively, we try to avoid problems created by too many people coming into the system. We have come up with a system of triggering insurance payments or health services by a physician making a finding of a diagnosable problem that can be treated by a specific application. And that flies in the face of what we know about older people with multiple problems, how they live, and what their needs are. Our discussion today tries to ask, how can we modify that kind of approach to providing the services we need? In fact, the witnesses have argued that is not the way to meet needs. We have got to build a caring system, of which doctors and medical services are only a part. We ought to divert a few of those medical doctors from providing acute care to provide long-term care. To make the long-term care system work, we cannot shift "excess" dollars from the medical side to enable us to provide social services. The argument that I have been making is that it is going to take more dollars, because most services delivered by medical professions in nursing homes and in the hospitals are essential services; we fool ourselves to think we can shift health dollars to strengthen the social support system that people need very badly.

Chairman HEINZ. I have some questions I will submit to all of you for the record, and I will give you a chance to make any additional comments you may have in a second.

I do want to bring up one question. I suspect I should address it to Jim Sykes. As you know, this committee has an interest in home equity and home equity conversion. A lot of people are talking about using home equity to finance long-term care.

We had a hearing called "Sheltering America's Aged," and at that hearing, one of the witnesses said that the net home equity holdings of older individuals currently in need of long-term care is probably $70 billion or more, and that 56 percent of all homeowners could generate $3,000 a year or more out of their home assets to pay for long-term care.

Assuming that those statistics are in the ballpark, what do you think are the barriers to tapping that equity, and if the barriers could be removed, how should that equity be used to provide for community-based long-term care?

Mr. Sykes. I appreciate the opportunity. I keynoted the first conference on home equity conversion to discuss home assets and how they can be used. Your question refers to barriers, and I think first off, that home—for those 70 percent who own their homes, of which 80 percent have paid-up mortgages—represents the very essence of their lives. Homeowners can say, "This home is mine; I am still self-directing, and the best evidence I have is that I live in my home." So the idea of spending down some of that asset is very, very difficult for people to accept and to understand. In a sense, it is like thinking that I could give you a part of my child's life, a little each month. So, we have an attitude problem.

Two, we have kind of an insurance policy attitude about this that says if these services ought to be mine by virtue of the fact that I live in the community, or that I have been a taxpayer all these years, why should you figure out some way to make me pay for these same services out of my estate or out of what I earned, while others may not need to do this?

They have had an attitude for a long time that their home is a contribution to the next generation; in a sense, they say: "I am a part of a society that is going on and on. I am not just the receiver of cash or services late in life, but I am also one who contributes." That whole concept is very deeply embedded in the minds of people. We have to find simple ways to make home equity conversion acceptable.

Chairman Heinz. What is the bottom line?

Mr. Sykes. Home equity conversion holds great promise so long as it provides more choices for older persons to use their own assets to enrich their lives in ways that they choose. Community services and national programs should be financed in a progressive, broad-based manner—not through a direct, mandatory dissaving system.

Chairman Heinz. I guess the way I would summarize what you just said is that you think home equity conversion should be facilitated, but for income maintenance purposes as opposed to health care.

Mr. Sykes. Yes; voluntary options for enhancing life as people choose, rather than mandatory requirements to pay for services that should be provided by the community and Nation.

Chairman Heinz. Are there any further comments?

Mr. Lane. I would just add, Senator, one of the real problems in home equity conversion is it is a gamble. We are in an area where changing actuarial demographics suggest a significant change in the lifespan on the upper end. Therefore, if an individual takes the gamble of home equity conversion, which generally has a payout period of about 10 years before the financing really runs dry, you have a portion of individuals taking advantage of an opportunity too early and then creating significant problems if they outlive that period of time.

I think it is a very promising area, and it certainly deserves the continued work of all of us, looking at how do we come up with diversified ways that make or offer use of resource and income.

I might say it is part of a victory, in part, Senator. You mentioned that I had helped you back in the days when you were in the House, and we got the Republican task force on aging underway, which was even a forerunner of the House Committee on Aging.

Chairman HEINZ. That was even before Claude Pepper became the senior citizens' sex symbol. [Laughter.]

Mr. LANE. We are aging gracefully, Senator. But looking back at that period of time, our focus was income. Some of our successes in the income area have given us this opportunity to look at private insurance, at home equity, and at other ways—annuities and resources, unlocking those resources—for a share of the elderly, their income and wealth distribution is better than it was 20 years ago. So, in looking ahead, we are really saying, thanks to some of our initiatives back 20 years ago, the elderly are in better income postures in many ways, in pensions and in Social Security.

Chairman HEINZ. Larry, thank you. If there are no further comments, I want to thank you all for being very helpful to us. Thank you for coming, long distances and shorter distances, both.

Ms. VERSNICK. May I say one thing, Senator, just a personal observation. In Kentucky, we do have a facility in a remote area of northern Kentucky, that has 15 to 20 percent of our patients who are on private long-term care insurance, and to talk to those residents, and to know that their assets are not being taken away, that they can be cared for and their families can come in, it makes much, much difference in those families. So it is viable.

Chairman HEINZ. Ms. Versnick, thank you very much.

Our last panel consists of Barbara Matula and Art Lifson.

Ms. Matula, you are the director of the Division of Medical Assistance of the North Carolina Department of Human Resources, Raleigh, NC. Would you please proceed?

STATEMENT OF BARBARA D. MATULA, RALEIGH, NC, DIRECTOR, DIVISION OF MEDICAL ASSISTANCE, DEPARTMENT OF HUMAN RESOURCES, STATE OF NORTH CAROLINA

Ms. MATULA. Thank you, Senator. You have also managed to slip another Pennsylvanian on your panel.

Chairman HEINZ. Are you an escapee—maybe we can get you extradited. We would love to have you back.

Ms. MATULA. I am a coal miner's daughter from Hazleton, PA. I have also served recently on a national Medicaid reform project that has considered so many of the issues that we have talked about today, the heart of the issue being that we lack a national, comprehensive strategy on how we are going to pay for and provide long-term care. When I say "long-term care," I do always mean home care as well as nursing home care.

But this has caused some really serious inequities in financing that affect both taxpayers and beneficiaries alike, some of which I think might surprise you.

I, of course, like to beat up on Medicare a whole lot because of its failure to meet the needs of the elderly in long-term care services, and I hope that we will not excuse Medicare's failings, simply because of their problems with financing now. Any serious look at Medicare reform has to take into account the issues that we have heard here today.

But, in the absence of Medicare reform, the States have had to fill the vacuum, and we have become the major financier of nursing home care through our Medicaid Programs. Now, last year in North Carolina, only 16 percent of our over 400,000 Medicaid-eligibles in the State were over 65 years of age. Yet they spent 40 percent of our $567 million budget for Medicaid. And even more shocking than that, three-fourths of what was spent for the elderly in North Carolina under Medicaid was spent for nursing home care alone, to benefit 27,000 elderly people.

Folks who are in competition with the elderly—and I have not even begun to talk about the disabled; the numbers are almost equal, if not higher—are the poor families and children we thought we were here to serve. A child in the Medicaid Program is costing the State about $400 per year for comprehensive care, compared to the $6,000 a year that we are paying to supplement nursing home costs for the elderly.

In our State, 70 percent of nursing home revenues come from the Medicaid Program; 25 percent from private pay patients, and a scant 5 percent from Medicare.

We feel that about half the patients who enter as private-paying patients become eligible for Medicaid. The other half do not often stay long enough to require assistance. Not everyone is in a nursing home for 2 years or more. Some are there for short-term, recuperative stays, and the families struggle, but are able to pay their costs. But of those who are there for extended care, we feel about half the private-pay patients end up on Medicaid.

And we have been talking so much about gaps. But I partly hold Danny Thomas responsible for the misunderstandings that the elderly have. They trust him, and they believe him, and I listen to him, and I get angry, when he says that his medi-gap insurance policy is going to pay for everything Medicare doesn't—and that is the key. This marketing approach suggests it will pay for everything that Medicare does not, rather than admitting it covers only your portion of costs for what Medicare will allow. It covers that part of the bill which is charged to you—and that is all that medigap is.

Unfortunately, the elderly learn better when they find themselves in a skilled nursing home or in an ICF, which is not covered at all. And while we may be very knowledgeable about the differences between ICF and SNF, and these acronyms slip off our tongues. The differences are meaningless to the elderly and to their family members.

So, during a lengthy nursing home stay, a lifetime of savings and investments, and finally, property, is exhausted, and then Medicaid will step in. Once the assets are gone, we will step in.

We test income as well as assets for poverty, and that is where the inequities fall hardest for the elderly. We pay the difference, as I said, of an average of about $500 a month to supplement the $500,

$600, $700, or $800 the patient has as a monthly income, to pay the monthly nursing home bill.

It probably will not please you to know that there are also folks who receive Medicaid who were not always poor, and who did not become poor because of a nursing home illness, but who received sound legal and financial advice on how to divest themselves of their substantial assets in a timely manner. There are limits, of course, on when they can apply for Medicaid, but those with the most assets to protect naturally will have good advice, and will be Medicaid eligible under the same basis as those who first exhaust their resources. Their monthly income will be applied, and we pay the difference. So we are the ultimate medi-gap insurance policy, except that we do cover long-term care.

I will leave to the insurance experts the discussion of risk and base, and all that, but I would like to make some marketing suggestions to them.

One of your staff told me that I was going to be remembered for suggesting that we market long-term care insurance under the term, "cover your assets," because that is precisely what a long-term care private insurance policy will do; it will protect the assets of the elderly—and they will not be the only beneficiaries. Their children and grandchildren who hope to inherit those assets will also benefit. So, concentrate your marketing strategies on the middle-aged "beneficiaries," as well as on the elderly Medicare beneficiaries.

I would say that—and I am sorry the red light is on; I should talk faster, but I can't—I am from North Carolina—the real question that we are facing is: Who is our mother's keeper? The average nursing home patient is 81, white, female, widowed. Who is our mother's keeper, and who is responsible for the cost of her care? Should we continue to make people who face catastrophic illness pay their own way? Should we recognize Medicaid for what it has become and extend its coverage to the middle income? Or, should we add on something like long-term care insurance, either privately or through the Medicare Program as an option?

Thank you.

Chairman **Heinz**. Thank you very much, Ms. Matula. If you had stayed in Pennsylvania, I am sure you would have completed your statement before the red light went on—and covered exactly the same material. [Laughter.]

[The prepared statement of Ms. Matula follows:]

Prepared Statement of Barbara D. Matula

North Carolina is among the top 10 States in America noted for the growth in its elderly population. As our citizens live longer, their chances of requiring nursing home care increase dramatically. The need for both institutional and noninstitutional long-term care services is growing and we must address the critical issues of how, as a Nation, we can best provide and pay for that care.

The absence of a comprehensive national strategy for long-term care creates a serious gap in our health care system and causes serious inequities in financing that care.

As the elderly and disabled who depend on it know, Medicare coverage of nursing home services is minimal, at best. Dr. Robert N. Butler, former head of the National Institute on Aging, said: "With Medicare, we set up a system for old people that assumed they were 40 years old. It often has little to do with the disorders old people really suffer."

While it may be an inopportune time to suggest that long-term care services be added to the Medicare program with all of its current financing problems, we cannot simply dismiss the issue by pleading Medicare insolvency. Any serious look at Medicare reform should include proposals to close the long-term care coverage gap in an efficient and cost-effective manner.

The historical failure of Medicare to provide extended care coverage has had a major impact on Medicaid expenditures in the States. In an attempt to fill the vacuum, State Medicaid programs have become the major financier of nursing home care. In North Carolina, 70 percent of nursing home revenues come from Medicaid, 25 percent from private-pay patients, and 5 percent from Medicare.

Medicaid was designed originally to provide comprehensive primary and acute care for needy families with children, and to supplement the Medicare program for the States neediest and disabled citizens.

Last year in North Carolina, only 16 percent of our Medicaid eligibles were 65 years of age and over, yet they spent almost 40 percent of our $567 million Medicaid budget. Three-fourths, of their costs or $166 million was spent on nursing home care alone.

Over half the patients who enter nursing homes as private patients end up on Medicaid. And while this has a dramatic effect on State Medicaid budgets, it also has a devastating effect on personal and family budgets.

Too many elderly persons believe Danny Thomas when he assures them that their Medi-gap policy covers what Medicare doesn't pay for. The harsh reality comes to light when the patient needs extended care either in a skilled or intermediate care facility and Medicare/Medi-gap is not available.

Family members struggle to supplement their parents' monthly incomes to pay for needed care but a lengthy stay for Alzheimers disease patients, for example, can quickly exhaust a lifetime of savings, investments and finally, property. When the patient's assets are exhausted he or she may become eligible for Medicaid which then pays for the difference between the patient's monthly income and the bill.

In addition to paying for those who become impoverished as the result of a lengthy confinement, the Medicaid program is also paying for the care of those who anticipated the risk of entering a nursing home later in life, and legally divested themselves of their assets before the need for care was apparent.

The more assets a person has to protect, the more likely they are to receive financial and legal advice on divestiture. Thus their legacies to their heirs are protected from the risk associated with extended care.

My pooint is this—that the Medicaid program has become the ultimate Medi-gap insurance policy covering long-term care services not only for the poor, but the formerly well-to-do as well.

This seriously erodes the original intent of the Medicaid legislation and causes inequities within and without the population it serves:

Needy families and children must compete for scarce Medicaid dollars with the elderly and disabled.

The elderly and disabled often lacking sufficient information on long-term care costs and Medicare coverage or noncoverage of those costs have no where else to turn.

Persons with considerable assets to protect are more likely to divest themselves of those assets to receive Medicaid coverage, which was intended for the poor.

Persons who have not divested themselves in a timely manner are left to pay the full cost of catastrophic illnesses until they become poor.

This is why I believe that in the absence of structural Medicare reform or as an interim step, the concept of long-term care insurance is a viable one.

To provide incentives and to assure the solvency of such an approach I would like to make the following observations.

RISK

Only 5 percent of the Nation's elderly are currently institutionalized. With continued expansion of home and community based alternatives this number should not increase significantly in spite of the increase in the elderly population. If most of the elderly were enrolled in a LTC insurance program (which included home care as well as nursing home care) there should be a large enough base to cover financial risks, provided strict measures are in place to control utilization.

INCENTIVES

A strategy to market long-term care insurance would require an initial educational effort to ensure that those at risk understood the current Medicare limits on coverage.

In planning for retirement, workers need to know that their savings are in jeopardy should institutional care be required. Early enrollment in LTC insurance plans may be the only way to "cover their assets" and safeguard their holdings to pass to their children and grandchildren.

Given this information, marketing strategies should include not only the potential Medicare beneficiaries but their adult children as well, who, in fact, become the beneficiaries of the estates if they are protected.

WHO SHOULD PAY?

Unless long-term care services are added to Medicare, Medicaid will continue to be the primary "insuror" for these services for both the rich and poor alike. We are faced with the dilemma of deciding either to continue our current policy of requiring those with catastrophic illnesses to pay their own way, or to recognize that Medicaid has become a taxpayer-supported insurance program for those who plan ahead.

Long-term care insurance could ease the financial burdens on the individual requiring extended care and on the family members who also stand to lose their inheritances.

Government support of this proposal at both the State and Federal levels is essential to insure equity for taxpayers and beneficiaries alike.

Chairman HEINZ. The next witness is Art Lifson, chairman of the Health Insurance Association of America Task Force on Long-Term Care Insurance.

STATEMENT OF ARTHUR LIFSON, WASHINGTON, DC, CHAIRMAN, TASK FORCE ON LONG-TERM CARE INSURANCE, HEALTH INSURANCE ASSOCIATION OF AMERICA, ACCOMPANIED BY JAMES A. DORSCH, WASHINGTON COUNSEL

Mr. LIFSON. And I have never been accused of talking too slowly so, as a native New Yorker and proud of it, here we go.

I am Art Lifson, assistant vice president of the Equitable Life Assurance Society of the United States. Today, I also represent the Health Insurance Association of America. With me is James A. Dorsch, Washington counsel of the HIAA.

As an industry, we share the concerns of this committee about the financing and provision of long-term care services for our expanding elderly population.

The current financing of long-term care is approximately equal between public and private sources. There would appear to be a growing concern on the part of Government particularly State government, that they will be unable to meet their obligations as the population ages and greater demands are placed upon the Medicaid program.

If there is the expectation that the private sector involvement in long-term care must expand, which I share, then there is a need for a public discussion and resolution of at least three items. You touched upon them this morning, and so I will make my brief comments even briefer.

The first is individual responsibility. To what extent will individuals be held responsible for financing their own long-term care needs? Do we as a society expect them to bear an increasing burden or a decreasing burden in the future? Are we willing to enforce existing rules on divestiture of assets or possibly make them stiffer?

Savings—what is the purpose of savings? We have recently increased the incentives for workers to accumulate larger capital assets than they would otherwise. For the most part, these incentives require deferral of receipt of income until after age 59½, and therefore are tied in many persons' minds to retirement. To the extent that these incentives for increased savings work, and they seem to be, then we can expect that the future retiree population will have greater personal wealth than is the case today. In addition, we can anticipate, because of ERISA and the changing nature of the work force, that many more individuals will retire with substantial pensions than is currently the case.

To date, we have not really had a public discussion of what we expect individuals to do with this increased wealth. Do we expect them to fund more of the long-term care bill from these tax preference amounts? Do we expect them to leave them in an estate? Are they even aware of what our expectations are, if we know what we expect of them?

That brings me to my last point—the awareness of the long-term care risk. Among the general population, even among 65 and 70 year olds, there does not seem to be the level of awareness of the risk of needing long-term care services that is necessary to provide incentives for individuals to protect those hard-earned assets.

I believe that we need a major public education effort in order to increase the public's awareness of this risk. A beginning effort at that is the report of the task force, which I chaired, on "Long-Term Care: The Challenge to Society."[1]

I am happy to report that the industry will be holding a conference on December 12 for itself, to educate itself about long-term care—what the prospects are, what the challenges and opportunities facing the industry are. Some of the challenges covered in that report concerning long-term care insurance products include such things as defining what is custodial care and how does one account for it; adverse selection; induced demand, et cetera—the pricing of a product.

There are several prototype insurance policies available in the marketplace. We are learning from them. The Firemen's Fund has one policy that has about 15,000 policies in force, and there is another company which I am familiar with.

Each of these new ventures into the marketplace provides the industry with additional information on the feasibility and viability of private extended care insurance programs. Private insurers' involvement will in all likelihood not be limited to insurance products, however, because we are now defining ourselves as financial services incorporations. Products could also include investments in life care communities and social/health maintenance organizations.

Finally, we should not lose sight of the fact that some—I do not know what proportion—of the 50 percent of long-term care which is financed by individuals comes from annuities, pensions, and other income replacement policies sold by insurance companies. I anticipate that those will, in fact, increase in the future.

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[1] See app. 1, item 3.

The industry, my company, and myself, certainly offer our services to this committee and any assistance that we can be to you in exploring this matter further, you just have to call on us.

Thank you, Mr. Chairman.

Chairman HEINZ. Mr. Lifson, thank you very much. Your prepared statement will be entered into the record at this time.

[The prepared statement of Mr. Lifson follows:]

PREPARED STATEMENT OF ARTHUR LIFSON

I am Arthur Lifson, assistant vice president of the Equitable Life Assurance Society of the United States. Today, I also represent the Health Insurance Association of America. With me is James A. Dorsch, Washington counsel of the HIAA. The HIAA is a trade association, representing some 335 insurance companies. Our members write over 85 percent of the health insurance provided by insurance companies in this country.

We appreciate this opportunity to comment on financing options for long-term care. We commend this committee for identifying long-term care as a major health policy issue. This important and complex problem requires thoughtful and balanced debate.

As an industry, we share the concerns of this committee about the financing and provision of long-term care services to our expanding elderly population.

More than 2 years ago, an association task force was established to explore this issue. A report, "Long Term Care: The challenge to Society," produced by the task force, is attached. In December, an industrywide conference will build on the task force report and expose industry representatives to the range of long-term care issues from a variety of perspectives.

Industry representatives have participated in numerous conferences and hearings called to bring interested parties together to begin a broad based effort to resolve some of the problems. In addition, individual companies have set up groups to explore the feasibility of private sector participation.

In its deliberations, the HIAA Long-Term Care Task Force identified some of the problems associated with the development, administration, and marketing of a long-term care product. These problems are not trivial. Solutions are not easily arrived at. And even if possible solutions are found, these will have to be tested in the marketplace to see whether they will work.

Some of the areas which pose problems for the health insurance industry include:

The need for better tools to assess the level and type of care required for people who often have multiple physical problems, sometimes accompanied by mental impairment. Care needs may shift from highly skilled health professional services to lower levels of custodial care.

The question of how to deal with custodial services which account for a large portion of extended care needs. The industry is geared to deal with medical and medically related problems. The range of activities of daily living—bathing, dressing, feeding—and companionship and other social support services falling in the custodial side of the care spectrum are beyond the current scope of insurance coverage.

Adverse selection, where demand is concentrated in a high risk population, is also of critical concern. If a balance between high- and low-risk insureds is not maintained, premiums may not cover claim costs, threatening the financial stability of the program. To compensate, the premiums may be raised to a level which would be attractive only to those most at risk, thereby compounding the selection problem.

There is considerable uncertainty about the additional demand which will be generated if long-term care coverage is offered. Little is known about the extent of care currently being rendered by family and friends. Projected utilization, a critical factor in premium pricing, offers considerable challenge to underwriters and actuaries.

Pricing difficulties abound for a benefit paid out years after premium levels are set. The rates have to reflect dynamic risks such as cost inflation, consumer tastes, consumer income, technological advances, and new care modalities.

A regulatory framework, conducive to the development and marketing of long-term care products has yet to be developed. For example in California, home care benefits are deemed to be more akin to disability income coverage, than to traditional medical expense coverage. Prefunding benefits at younger ages will involve consideration of cash values. A practical regulatory framework needs to be shaped to accommodate the successful underwriting and marketing of longterm care coverage.

Other areas requiring further examination include ways to educate consumers to the potential need and costs of long-term care services to heighten awareness of the desirability of factoring long-term care requirements into retirement planning, the structuring of products for the under-65 population, and the development of incentives to encourage the purchase of long-term care coverage.

We are dealing with an uncertain environment. Gathering supporting data and experience will be a costly and time consuming process.

The commercial health insurance industry is involved in long-term care financing on a limited basis. For example, the Fireman's Fund has been test marketing for 10 years and currently has about 15,000 policies in force. Over the years, the policies have been modified to reflect experience and various State regulatory restrictions. Coverage is for a maximum confinement of 4 years in a skilled nursing facility, a daily benefit of up to $70 and a 20- or 100-day elimination period. Because of concerns about jeopardizing the plan, the company is proceeding cautiously in order to gain a thorough understanding of the product.

The United Equitable Insurance Group has marketed some form of nursing home product since the mid 1970's, and current policies in force exceed 60,000. The original plan, covering 1 year of skilled care, was revised 4 years ago to cover 4 years of skilled care and up to 12 months of intermediate or custodial care at a reduced level of reimbursement.

Each venture into the marketplace provides the industry with additional information on the feasibility and viability of private extended care insurance programs.

Long term care may well be the major health policy issue in the coming decades. The industry and individual companies are exploring the problems and seeking solutions. Both government and private resources are required to meet current challenges and plan for the future needs of our expanding elderly population. The Health Insurance Association of America stands ready to join in the public debate and offers its assistance to this committee as it deliberates this pressing national problem.

Chairman HEINZ. Those three bells mean that we will have a quorum going live in about 7 minutes, so I will not be able to ask you all the questions I want to ask you, but do not worry, I have a few.

Ms. Matula, you have had some experience as I am aware, with the 2176 project; is that not correct?

Ms. MATULA. The home and community-based waivers?

Chairman HEINZ. Yes.

Ms. MATULA. Oh, yes.

Chairman HEINZ. Do you think that those projects will yield useful information and data to assist private insurance companies in developing long-term care, or what I prefer to call independent living insurance policies? I prefer it, because I do not think they made a lot of money selling death insurance, but life insurance is insurance against death. I would prefer to call it not nursing home insurance, not home health care insurance, not insurance against some long-term, debilitating, crushing illness, but independent living insurance, which is the benefit that it conveys.

What do you think?

Ms. MATULA. I like independent living insurance. I think that is excellent.

I know that the States could teach the insurance industry a great deal from what we learn, if we ever get an opportunity to put these waivers into effect. If I were giving them any advice, I would say that they are lucky they do not have to deal with our Federal friends, who are not willing to grant the waivers to the degree that we need them to experiment.

Chairman HEINZ. Furthermore, you have met the enemy, and it is us. [Laughter.]

Ms. Matula. Our friends in EOMB do not believe that home and community-based services are at all cost effective. They do believe that we will be serving an entirely new population. And, rather than give us some opportunity to prove or disprove the cost effectiveness, we are being hamstrung and just choked to death on these waiver requests.

So, should we ever get them, I am sure what we learn will be helpful to the insurance industry.

Chairman Heinz. These waived programs, some operating for a few years now, will offer useful information. I guess my question to Mr. Lifson is, are insurance companies watching these projects closely?

Mr. Lifson. Well, we are aware of the projects which have existed to date, and are aware of the new experiments that are taking place, and, yes, we are looking and anticipating the results from them.

Public programs and private insurance, though, are horses of a different color. In many cases, the public program, one is entitled to; the private insurance program, you have to reach into your pocket and want to buy something. I think that is a fundamental difference in terms of looking at the population.

Chairman Heinz. Ms. Matula, do you have a comment that you want to make on that?

Ms. Matula. Oh, yes. I do not know if it is worth repeating.

Chairman Heinz. It may be worth repeating it.

Ms. Matula. The public health programs have taught the insurance industry a great deal on how to be more cost effective, and I think we can teach them the same in the home and community-based services area, if given a chance.

Chairman Heinz. Mr. Lifson?

Mr. Lifson. I have no objection to that statement at all. In fact, I endorse it, and it is absolutely true. The States were under a lot more pressure before our customers, fortunately, woke up.

Chairman Heinz. Ms. Matula, short of expanding Medicare to cover long-term care, what can the Federal Government do to work with State governments to improve coverage?

Ms. Matula. I think that we need to separate the Medicaid Program into the two distinct populations it serves, and then untie the elderly and disabled who need chronic care, chronic illness care, from those artificial eligibility requirements. This institutional bias that you hear about occurs, in part, because we are bound to eligibility requirements that apply to AFDC families, who probably have no assets, whose income is their only measure of poverty. I think that if we did that, and we took Medicaid out of this all-or-nothing approach, we might be able to help the middle-income and lower income elderly pay for their care without paying for all of their care. It would be a way we could help.

Chairman Heinz. What exactly would you do?

Ms. Matula. We would have to amend the eligibility laws as they stand——

Chairman Heinz. Oh, I understand, but how would you change them? Give me a specific example of how you would in fact change the eligibility laws.

Ms. MATULA. Right now in North Carolina, for the medically needy who are aged, blind, and disabled, I am limited to setting their monthly income standard at one-third higher than AFDC. So, I may be limited for a single, elderly individual living at home, to $200 a month to pay for all their living expenses—unless, of course, they are on SSI. If that patient, if that client has a $500 per month Social Security check, he or she has to pay $300 of it on health care before I can give him or her a Medicaid card to help pay for home-based care. But if that client goes into a nursing home, we will let him keep $25 and apply the remaining $475 to the nursing home bill, and we will pay as much as $1,000 a month for his care. If we could use a different income standard to provide at-home care for the elderly and disabled, a more liberal and a more generous one that recognized the cost of living at home, we could serve the people in the community much better and much more cheaply.

Chairman HEINZ. Mr. Lifson, in the limited time I have, let me turn to what your task force discovered. It seems to me from some of the comments I have heard—you have echoed a few of them—that insurance companies seem to think there are an awful lot of unknowns—you mentioned adverse selection, for example—and are very nervous about knowing how to insure long-term care.

Should I be picking up here that maybe many companies are using these as a reason to not even test-market any product?

Mr. LIFSON. No, I do not believe so, Senator. I think these are, in fact, legitimate concerns, concerns we have when we enter almost any new product, almost any new service. We are putting up hard-earned capital, and even the test marketing of a particular product can be a very expensive operation, so one has to be very careful with, in my case, my policyholders' money, and, in other companies' cases, their stockholders' money.

These are real concerns. We are learning. There are a number of companies who have bit the bullet and have gone out and are marketing products, are reporting their results—I think favorable results on their part will lead others to enter the marketplace.

Chairman HEINZ. You work for an insurance company in addition to having headed the task force. Are you a marketing man or an actuary?

Mr. LIFSON. I am neither, Senator. I am a social worker by training who happens to be responsible for government relations for the group department of the Equitable, including paying Medicare claims in four States.

Chairman HEINZ. That needn't disqualify you from answering the question I was going to ask you, anyway. [Laughter.]

Going back to adverse selection, what about the idea of using the medi-gap policies that are out there—which two-thirds of the elderly have—as a vehicle for long-term care? It seems to me that makes a lot of sense, because in a sense, one of the barriers to successful market penetration here is senior citizens' perceptions that they are covered by medi-gap policies, or Medicare, or both, and talk about a better mousetrap—people are in one, and do not know it, and you have an opportunity to really redesign the entire situation. What about that? Is anybody building off of their medi-gap to kind of have a super medi-gap?

Mr. LIFSON. My company is one that has never been in that market. The Equitable involvement in the supplemental medical insurance market has always been on a group basis, so I cannot talk for the Equitable. I do believe, though, some of the members of my task force came from companies who were, in fact, in that market. I believe that they are, in fact, exploring just the sort of thing that you were talking about. Whether or not they and their managements will make a decision to enter the marketplace with it, that, I cannot tell.

Chairman HEINZ. What about the notion of spreading the risk more broadly by marketing policies not just to the elderly themselves, but further, earlier down the income stream, such as to families?

Mr. LIFSON. I personally believe that one of the keys, if we are going to be successful in solving the financing problem, is increasing the awareness of people at younger and younger ages of their potential risk, so that they then can make provisions to protect themselves from that risk. One of the answers for that protection could, in fact, be insurance, but I would not limit myself to insurance. People seem to be able to plan increasingly well for their retirement and meeting their income needs. They are unaware in doing that planning, however they do it, of their potential risk of meeting long-term care services.

I am convinced that if they were aware of those risks, an increasing portion of the population could finance out of income and assets their long-term care needs—and that would include purchase of insurance, but it also could include annuities and a wide variety of other things.

Chairman HEINZ. The private pension industry is booming, either because of or in spite of—depending on who you listened to last week—ERISA. And the reason so many—close to half, as I recollect, of people are covered by a pension, either defined benefit or defined contribution—is probably twofold: First, they have been collectively bargained for, and second, they have received tax breaks, the same way as employer-based health insurance has received tax breaks.

To what extent, first, are tax breaks needed for long-term care insurance, or if someone had a policy that was offered by employers—let us say it was or was not collectively—bargained for, but it was the kind of thing we have been talking about today, not just nursing homes, but we found a way to solve some of those other problems—would it be eligible for the kind of tax treatment we now accord health insurance?

Mr. LIFSON. Well, I am not a tax attorney, but I would surmise that an employer-sponsored plan under current rules would, in fact, qualify currently as——

Chairman HEINZ. So tax policy is not a problem here?

Mr. LIFSON. It depends upon how you define it. Let me defer to my counsel, here.

Mr. DORSCH. I have to point out, Senator, that you are 100 percent correct as to what the situation is today. But when I listened to the dialog about care at home, and your conversations with Senator Warner, about the need for tax incentives, and I look at the chart up there and see what the elderly are spending now out-of-pocket, more and more of that money is coming out of the pension plans provided at the workplace, as well as group life insurance and group health insurance. But there is a very strong move afoot, as I am sure you are aware, in the tax-writing committees, the Treasury Department and the IRS, to cut back on those tax-favored plans, which we believe are moneys very, very well spent to care for our senior citizens in their old age

And whereas this committee is going in one direction, I might say that perhaps one hand doesn't know what the other is doing, and other parts of the Congress are going down a road that is 180 degrees from the road that you suggest.

Chairman HEINZ. There is an administration proposal to cap health insurance to the employee who is a beneficiary of health insurance, to $125 a month or whatever it is. I do not know of any similar effort with respect to pension benefits.

Mr. DORSCH. Well, there is certainly a great deal of discussion that centers around capping all employee benefits, and there is already a cap on group term life insurance. The Ways and Means Committee is going off on a retreat next week to discuss overall deficit reduction, but they have just had a hearing, as the Senate Finance Committee has, on the taxation of all employee benefits.

Chairman HEINZ. Nothing, no barrier, should be put in the way of the House of Representatives when it comes to deficit reduction. They need a barrier-free environment.

I sense that the thinking on long-term care insurance has tended to revolve around either new products or building off of health insurance products. Am I wrong in thinking that no one is really building off of retirement plan products?

Mr. LIFSON. I think people are beginning to—you know, we are rather new to this, and we are learning all the time. I think life care communities, which is one way of socializing the expense and the risk of long-term care, is one item which I think a number of companies are looking at, and that would not, obviously, be strictly health insurance involvement.

There are other items, such as social HMO's. I happen to be on the board of one. It is a very interesting sort of thing. It is just getting off the ground. We are in the business of making investments, and I think if they prove out, they will be a pretty clear way of melding delivery needs and containing the expense and managing the care that people need.

Chairman HEINZ. The Ways and Means Committee may have put a nail in the coffin of life care communities by prevailing in conference on the imputed interest issue, so that it is now very difficult for a senior citizen to make a downpayment to a life care facility under most of the arrangements that are required without somebody from the Internal Revenue Service coming along and saying, "Somebody owes us a lot of money here."

Mr. LIFSON. I was not aware of that, Senator, and we will, of course, have to look into it.

Chairman HEINZ. I urge you to look into it.

Ms. Matula, I have noticed several indication of the desire to be recognized, when Mr. Lifson was speaking. I did not mean to silence you.

Ms. **Matula.** If educational opportunities were effective, we would want to buy into long-term care insurance as early in our working lives as we possibly could, so that it would be the cheapest. Could there not be another block for the Medicare Program that were such a program, that was optional, hat would entitle you to benefits only if you had contributed throughout your working life, as you do for your hospital insurance, as we do for our Social Security deductions.

Chairman **Heinz.** I think that is an interesting idea, and it really was behind my questions on building off of pension plans.

Ms. **Matula.** Optional and tax exempt.

Chairman **Heinz.** Because there are great incentives for people to get into pension plans at an early age, due to the way vesting and accumulation of benefits tends to accelerate, and the sooner you get in, the better it is you are.

Ms. **Matula.** The risk should not be bad. Only 5 percent of our elderly now are institutionalized. Not everyone who retires goes directly to a nursing home. I think that it could be handled. But the broader the base, and the younger the working population contributing, the cheaper it would be for all of us.

Chairman **Heinz.** I thank you all. I regret we are going to have to adjourn the hearing.

Thank you very much for your excellent policy suggestions, and we look forward to continuing to be in touch with you.

Thank you all very much.

[Whereupon, at 11:56 a.m., the committee was adjourned.]

APPENDIXES

Appendix 1

MATERIAL SUBMITTED BY WITNESSES

ITEM 1. MEMORANDUM, "IMPROVED COVERAGE FOR LONG-TERM CARE INSURANCE," SUBMITTED BY LAURENCE LANE, AMERICAN HEALTH CARE ASSOCIATION, DATED AUGUST 3, 1983

As we discussed during our meeting 2 weeks ago, there is a very strong consumer demand for private long-term care insurance which covers both facility-based and community-based services. This point was emphasized during the May 15 AHCA Policy Forum on Private Long-Term Care Insurance. While fully cognizant of the resistance which you are confronting from underwriters in expanding long-term care coverages, it is important to emphasize the need for a balanced policy which reflects payment for both institutional and noninstitutional services.

The following are several ideas which I believe might assist in improving coverages. These ideas are formulated using your directive that policy expansions must be "evolutionary," not "revolutionary." These are professional ideas based upon conservative assumptions and do not necessarily reflect association or personal preferred actions:

(1) Continuum of Care Coverage

The policy which offers the most options to the consumer to have some control over the care determinations made upon their behalf will be the most marketable. There is a consumer preference for professional services in the home. A meaningful long-term care policy must address this market.

Attachment No. 1 [1] is a "Healthcare Financing Review" article on Medicare's experience with part A coverages. Four distinct care options are witnessed. The most prevalent pattern for part A is inpatient hospital without followthrough care (90 percent cases/83 percent cases age 85+). Hospital care followed by home health agency care constitutes the second most prevalent pattern (5.2 percent of the cases/7.3 percent of the cases are 85+). Hospital care followed by skilled nursing facility care occurs in 3.3 percent of the cases, but is witnessed in 8.5 percent of the cases for individuals over the age of 85. Trilevel services (hospital, skilled nursing and home health) occur in less than 1 percent of the cases, but slightly over 1.2 percent of the cases involving someone over the age of 85.

Recognizing the limitations of applying Medicare data to actual long-term care experiences, this information suggests exposure following prior hospitalization is not as risky as perceived. It also points to three distinct post-hospital care patterns which should be considered in designing a policy, i.e., (i) hospital to home care, (ii) hospital to nursing home and (iii) hospital to nursing home to home care.

(2) Limited Exposure Insurance Approach

Current insurance experience has confirmed the insurability of long-term nursing home care. The indemnity based payment following prior hospitalization and a specific exclusion period permits a dollar calculation of high and low range insurance exposures. This experience provides a definable base for modest changes in the benefit which (i) respond to consumer demand, (ii) offers greater flexibility in care patterns and (iii) reduces the incentives for inappropriate placement.

Consideration should be given to the following benefit options:

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[1] Retained in committee files.

Option A: Hospital—nursing home.—Coverage as discussed in our correspondence of June, providing 3 to 4 year indemnity policy with exclusion period, indexing of the indemnity to a trending factor which safeguards the purchasing power of the insurance.

Option B: Hospital—nursing home care.—Specific provision over and above the existing marketed policies which provides an incentive for discharge from the nursing home (perhaps a month or two full indemnity transition) and a followthrough benefit determined as a percentage of the transition benefit for a defined timeframe.

Option C: Hospital—home care.—Experimental coverage which offers an option for discharge to the home for professional services, with the indemnity set as a percentage of the inpatient nursing home benefit, total benefit capped at the mean cost experience with inpatient nursing home trended forward for a timeframe actuarially determined (with potential to broaden coverage based upon actual experience). Policy could include exclusion period similar to that used in the nursing home policy, however, a shorter exclusion period might discourage inappropriate nursing home stay while encouraging use of the less costly policy coverage (less costly because the indemnity has been reduced).

Ideally, a relationship could be developed among the care options which would determine the costs involved of restoring existing coverages. For instance, individuals exercising option B could preserve a proportion of their option A coverage; likewise, individuals exercising option C could continue to have available a portion of their option A coverage. A policy rider could be developed which offers the optional coverages of a restorable benefit, however, it would appear the initial costs of this provision might be too high for the mass market.

(3) Gatekeeping

One of the areas which requires careful review is the gatekeeping function. Most policies (i) mandate prior hospitalization, (ii) specific exclusion period before benefit begins, (iii) require physician certification, (iv) define a path of services, and (v) allow for claims reviews. Reviewers are based upon medical determinations without consideration of (i) social circumstances which mandate facility based services, (ii) imperfections of levels of care determinations, (iii) appropriateness of geriatric assessment, and (iv) appropriateness of placement. Few of the companies underwriting existing policies have sufficient risk experience to standardize claims review.

Inspite of the imperfection in these controls, they have served to deter abuse of the policies. An extension of coverages to home care under these existing controls might not induce as much demand as envisioned. First, while the prior hospitalization screen is ineffective as a control, it often triggers Medicare coverage which provides extensive home care assistance. Second, the controls imposed upon nursing homes are often "piggy-backed" upon public programs, i.e., licensure, certification and classification. This precedent could be carried over to home care, thus limiting the absolute number of providers eligible for payment through the program. Third, a path of services could be prescribed in the home setting comparable to the step down in benefits used in some policies differentating skilled and intermediate, intermediate and custodial services. In the home setting, it is possible to distinguish benefit coverage and indemnity, i.e., services must be provided by a certified agency and consist of nursing plus another service.

Understanding the constraints upon you to consider any home care option timidly, consideration might be given to proceeding with the above options and then developing a more encompassing pilot demonstration. Enclosed[2] is a second "Healthcare Financing Review" article which discusses nursing home preadmission screening. As you consider HMO relationships and relationships with long-term care public programs, you might desire to consider contracting arrangements with existing services to improve screening decisions. The Department of Health and Human Services has funded a number of channeling programs and service improvement projects. It might be to your long-range interest to work with one or more of these demonstration sites offering extended coverage. This willingness to experiment could give you valuable information, would enhance public awareness of your product and extends good will in the long-term care marketplace.

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[2] Retained in committee files.

ITEM 2. PRIVATE INSURANCE FOR LONG-TERM CARE: AVAILABILITY, PROBLEMS, AND ACTIONS, PREPARED BY LAURENCE LANE, AMERICAN HEALTH CARE ASSOCIATION

AHCA INITIATIVE ON LONG TERM CARE INSURANCE

PRIVATE INSURANCE FOR LONG TERM CARE

In response to the preceived need for enhancing private sector financing for long term care services the Division of Federal/State Relations has undertaken an intensive review of the potential for long term care insurance. As the following review of activities indicates, there is a significant potential for a private insurance response to the payment for long term care services. This report will:

- provide an assessment of current policies,
- discuss the reasons for the market's failure to provide coverage,
- identify on-going activities, and
- make recommendations for additional AHCA involvements.

(1) **Background:**

Skilled nursing care, and related forms of extended care, such as home health care, intermediate care and domiciliary care, have become an increased source of national expenditure, increasing tenfold between 1960 and 1980 (Gollub/SRI International, 1983). Forty-three (43) percent of outlays for nursing home care came from private sources in 1977 (NCHS, 1979). HCFA data indicates that for the year 1979, of the $17.8 billion expended for nursing home care, $7.7 billion reflect private funds. Private insurance is estimated to contribute only $117 million of such sums (HCFA, 1983). Nursing home expenses are cited as the largest catastrophic expense for those aged 65 and over (Birnbaum, 1981). Area specific data accumulated by GAO suggests that a significant number of nursing home residents enter as private pay patients and become eligible for Medicaid after exhausting their resources. For example, in Minnesota, data indicates that one-fourth of the patients admitted to Medicaid coverage in nursing homes between 1977-1979 had actually entered nursing homes at some point earlier as private pay patients and subsequently converted to Medicaid (GAO, 1983).

The two features of the structure of the nursing home industry which makes it unique are the limited capacities of its consumers and the dominance of government as both payer for nursing home services and regulator of the activities of the industry (Vogel, 1983). The National Center for Health Care Statistics found that on one day in 1977, sixteen (16) percent of the 1.3 million residents had been there from three (3) to five (5) years, and thirty-three (33) percent from one(1) to three (3) years. While the median length of stay for nursing home residents on the day of the survey was under three (3) months -- (seventy-nine days) -- a small proportion of residents stayed far longer, so that the average stay was calculated as being over one(1) year -- four hundred and fifty six days (NCHS, 1979). A statistical model developed by the General Accounting Office suggests two profiles of nursing home residents, one with characteristics of short-stay (average of less than two months of residency), and one of a longer stay (two and one half years average) (General Accounting Office, 1983).

To examine the potential role of private financing of long term care, it is important to understand the resources of different groups of the elderly.

In a June 1983 preliminary report to the Office of the Assistant Secretary for Planning and Evaluation (HHS), ICF, Inc. (a Washington, DC consulting organization specializing in pension and actuarial calculations), provided a detailed analysis of income and resources of the elderly. According to the research, if older persons had the opportunity to "annuitize" their income and resources, approximately one-third (33%) of elderly couples and over one-quarter (26%) of single persons had wealth which could produce an annual annuity value of $5,000 or more. Adjusting this amount for age using actuarial assumption projections, the research indicates that almost forty (40) percent of the elderly over age 80 could convert their assets into an annuity of $5,000 (ICF, 1983). Such findings are consistent with the data collected by the National Center for Home Equity Conversion (Scholen, 1983). Separate from the analysis including resources, ICF estimated the percentage of families to whom long term care might be affordable based upon available income. As shown below, a significant share of the elderly could afford premiums which would be less than ten (10%) percent [five (5%) percent] of cash income:

ICF Estimates of Affordability at 10% (5%) of Income:*

	Age 65-69	Age 70-74	Age 75-79	80+
married couples	82% (50%)	67% (27%)	38% (12%)	23% (6%)
single persons	80% (44%)	65% (27%)	41% (16%)	29% (10%)
total	81% (47%)	66% (27%)	40% (14%)	27% (9%)

* assuming an annual premium in 1983 dollars for an individual age 65-69 of $450, 70-74 of $550, 75-79 of $775, and 80 and over of $900. Premiums for couples are twice these levels.

(2) Assessment of Current Policies:

Private insurance offers one of the more promising of the market approaches to underwrite the costs of long term care. For years, there was great hesitation by the insurance market to provide health benefits to older persons. During the mid-1950's this barrier was successfully pierced with the advent of group plan coverage for retired teachers and retired professionals under the auspices of the National Retired Teachers Association/American Association of Retired Persons. While the market remained small, in part because of the political debate for a Federal program, there was a positive growth curve throughout the decade prior to Medicare. With the advent of Medicare, the focus of the health insurance industry shifted to a supplemental role providing coverage of deductibles and coinsurance features. During the 1970's this market grew substantially. According to one recent analysis, about two-thirds of the aged population had private insurance supplemental to their Medicare coverage (Carroll & Arnett, 1981). This coverage was primarily purchased by the individual.

As the market for supplemental insurance, the so-called Medigap insurance, grew during the past decade the benefits altered to meet the competitive demand. In 1976, less than six million (6,000,000) supplemental insurance policies indicated coverage for nursing home care of any type. Nineteen seventy-nine (1979) data indicates more than a doubling of coverage with over thirteen million (13,000,000) policyholders receiving some Medigap coverage for nursing home services. At the same time, the number of individuals covered by a supplemental health insurance policy only grew by about three million (3,000,000) policyholders (Carroll & arnett, 1981). This data would suggest that nearly half of the elderly (estimate of 48%) have some coverage for at least a share of the costs of nursing home care. Unfortunately, the depth of coverage appears to be tied closely to the coverage afforded by Medicare. Thus, while the breadth of coverage has been extended, the depth of protection has remained limited. Most of the nursing home coverage afforded by Medigap policies pays for required deductibles and coinsurance mandated under the Medicare program for skilled nursing care between the 21st and 100th day. Some policies are slightly more generous providing a fixed number of days of payment in a skilled nursing facility but delimit their coverage to utilization controls of the Medicare program.

An attempt has been made by ICF to estimate the size of the population which has been able to secure insurance coverage for long term care services more extensive than those covered by the typical Medigap policy. The preliminary estimate suggests that upwards to fifty thousand (50,000) individuals have been able to secure market coverage for comprehensive long term care services (ICF, 1983). A composite of the research available suggests the following companies as providing offerings covering long term care:

- Fireman's Fund, San Rafel, CA
- Federated American Life/Sterling Credit Life, Springfield, OH
- Massachusetts Indemnity and Life, St. Louis, MO
- Great Republic Life, Seattle, WA
- United Equitable Insurance, Skokie, IL
- Health Insurance Corporation, Milwaukee, WI
- Equitable Life and Casualty, Salt Lake City, UT
- Kemper group, Long Grove, IL
- Merchants and Manufacturers Insurance, OH
- Pacific Benefits, Seattle, WA
- National Foundation and Life, Oklahoma City, OK
- Columbia Accident and Health, Bloomsburg, PA
- Mutual Protection Insurance, Omaha, NE
- Transport Life, Fort Worth, TX

Limited policy coverage:

- Prudential (AARP Plans and other group coverages)
- Bankers Life (reportedly a supplemental rider)
- Mutual of Omaha (reportedly a supplemental rider)
- American Life and Casualty
- Aetna (limited offering as a supplemental rider)
- Montgomery Wards (NAMP group plan)
- Colonial Penn (old AARP plan)

Group offerings:

- Blue Cross of North Dakota (still experimental)
- Blue Cross of Southern California (Ultracare -- HMO Plan)
- United Auto Workers/Blue Cross of Michigan
- S/HMO of Brooklyn (ElderPlan)
- S/HMO of Portland (Kaiser)

Attachment #1 is a summary of the four most cited long term care plans offering coverage as taken from the ICF June 1983 report. Attachment #2 are summaries of additional plans reviewed by Mark Meiners of the National Center for Health Services Research.

It is most important to note that the available offerings provide indemnity benefits for extended nursing home stays. The benefits vary with regard to the amount of indemnity paid, the length of time benefits are provided, the waiting period before benefits become effective and the conditions upon which benefits will be paid. The indemnity benefit limits the insurer's liability and reduces the risk of providing insurance. Many of the initial health policies underwritten for older person, including most of the group plan policies marketed through the American Association of Retired Persons were indemnity coverages.

Another characteristic of the current policies is a deductible or a reduced benefit period as a means of controlling unnecessary utilization. Most of the existing policies limit their benefits to facility based services, although it is possible to get a rider for home based care. Attachment #1 provides several good examples of the variety of coverages for custodial and intermediate care benefits. Likewise, most of the current policies restrict benefits to a period of three or four years.

Premiums for most of the available policies are aged rated, i.e., premiums increase with the age of initial insurance purchase. This practice has been questioned by Meiners in his writings. Mark has developed a prototype policy for the National Center for Health Service Research which suggests financing similar to a whole life insurance policy with level premiums. The age related approach is more analogous to term life insurance. It is unclear whether the current debate on discrimination against women in insurance coverage will impact upon the development of a long term care benefit. The aged rated benefit could be shown to factor the longevity of women, and, therefore, have an element of discrimination.

Most of the current plans have elaborate utilization controls. These include the use of one or more of the following:

- medical screens and physical examinations
- pre-existing condition limits
- prior hospitalization requirements
- restrictions on coverage for mental, alcohol and drug related requirements
- definitional restrictions on types of coverage and services purchased.

As emphasized by the ICF data, the market experience is limited. While the number of policies purchased has grown, the utilization of the coverage has limited documentation. Therefore, it is difficult to define the range of service utilization.

(3) Reasons for Limited Market Development:

Several researchers have explored the problems of developing insurance coverage for long term care. Each have cited their findings for the slow expansion of the private sector into this important area of coverage.

In perhaps the most exhaustive study of the subject, Mark Meiners suggests the following factors which he characterizes as "market failures:"

- traditional insurance concerns of adverse selection, moral hazard, administrative diseconomies, and premium pricing difficulties due to inflation.
- absence of reliable data on which to base estimates of utilization, costs and experience.
- state insurance regulations which inhibit or prohibit coverages.
- the availability of public long term care programs which serve as as safety net for those who are poor or may become poor.
- consumer preference for first dollar coverage.
- consumers under estimation of their potential need for long term care coverage and over estimation of the available coverage of their existing insurance policies and of public programs.

This latter point is perhaps most important. Writing in the AHCA Journal two years ago, AARP's staff insurance expert Ron Hagen pointed to several additional problems: misinformation, deception, and less than complete understanding of the potential policyholder's coverage and its limitations. Hagen also suggests that the restrictive underwriting requirements to compensate for insurance risk might be a significant market disincentive. More recent papers prepared by Dr. Friedman at Northwestern University and by the staff of the Health Consortium at Brandeis reiterate these points as market problems.

In looking at this list, it is interesting to note that the experience of medical screens for both Fireman's Fund and Pacific Benefits document that they have rejected a greater number of applicants under the age of 65 than over the age of 65, indicating that adverse selection in the purchase of long term care insurance may be a greater problems for the younger age group. Pacific Benefits has also documented a rejection of policy applicants over the age of 80, but the experience has been limited compared to the total applicant pool. Current policies tend to restrict coverage through the use of pre-existing conditions restrictions and coverage exclusions. Many of the current policies would not cover organic brain disorders (including Alzheimer's Disease) and mental health services. In some instances, the pre-existing condition limitations have included maternal related complications.

Attention should be directed to two of the cited market failures. First, there is widespread public misunderstanding of both the risks they confront in the normal aging process and of the protections which they have purchased through their insurance coverages. The Medigap policies have sometimes been marketed without clearly stating the protections afforded for long term care. Continual focus by public programs to the goal of prevention of premature placement in a facility based long term care program has misled the public that the risk does not exist. Second, the interplay between the Medicaid program and the purchase of long term care needs to be carefully assessed. The evidence which supported changes in the divestiture provisions of the Medicaid program suggests widespread public "gaming" of the system to avoid assuming the responsibility for purchasing services. The Medicaid nursing home protection has been characterized as a "middle-class" catastrophic care program where in residents of nursing homes enter as private pay and spend down to become eligible for the public entitlement. Whether this is fact or an overstatement of reality needs to be carefully analyzed.

(4) On-Going Activities:

Slowly, research is being generated to stimulate the private market to extend coverage for long term care. The following is brief annotated review of identified activities:

- o National Center for Health Services Research: Dr. Mark Meiners has been in the forefront of raising the private insurance issues. Meiners has authored a number of articles, including one for the AHCA Journal, March, 1980. Meiners' prototype policy presented in his paper, "Private Coverage of Services Not Covered by Medicare: The Case for Long Term Care Insurance," October, 1982, is at the center of the debate.

- o ICF: John Valiente has received a grant from the Assistant Secretary for Planning and Evaluation (HHS) to study private financing. The June, 1983 interim report on the subject is most interesting. This report is being revised with further analysis and direction (I recently assisted John on the revisions) and should be available early next year.

- o Health Consortium at Brandeis: Several policy papers have been prepared by Stan Wallack and staff. Christine Bishop has continued her work on a social insurance approach which would mandate long term care insurance via public mechanisms. The Health Consortium provides the support to the Social HMO (S/HMO) demonstrations, two sites of which are developing insurance coverages. Wallack has become very interested in retirement centers which share the risks among residents. A paper was delivered at the Aging 2000 Seminar in October, 1983, (conducted by the Texas Research Institute for Mental Sciences) outlining the status of work on insurance by the Health Consortium.

- Prudential/AARP: Ron Hagen has been given lead responsibility in working with the Prudential Insurance group plans to perfect coverage for the American Association of Retired Persons. Hagen outlines the directions he is pursuing in his September, 1982 article in the AHCA Journal.

- Center for Health Services and Policy Research, Northwestern University: Friedman's group has a marketing project underway, attempting to identify the issues which would influence acceptance of insurance coverage by the elderly. Information from the project which was designed about a year ago should be forthcoming.

- Health Insurance Association of America: Art Lifson (Equitable Life Assurance Society of U.S.) and Purlaine Lieberman (HIAA staff) have led a task force looking at the prospects for market development. In an overview to the report presented by Lifson in a program sponsored by the Ritter Department of Geriatrics and Adult Development (see below), he questioned the merits of the private sector underwriting long term care. Lifson raised a number of technical problems in developing insurance coverages, i.e., available data, market failures, uninsurable risks, and he suggested that firms should look to the next generation of elderly (those between 35 and 55) as the market segment which could be insured. The HIAA Report has received a great deal of attention.

- SRI International: Jim Gollub has been spearheading SRI's review of Medicare Supplemental Insurance (Medigap) policies. This is a market and it can be penetrated. Gollub will be writing on long term care insurance in the upcoming series on LTC by the Healthcare Financial Management Association. Gollub would like to get funding for his approach of building private and public decision teams working to develop a better understanding of aging, long term care and coverages.

- Mt. Sinai/Ritter Department of Geriatrics and Adult Development: Dr. Butler is most interested in developing private insurance for long term care. As his first act as director of the Mt. Sinai program, he put together a symposium on private insurance coverage. Butler has floated the idea of putting together a Blue Ribbon Panel of leading figures to spearhead a development task force. This plan might get off the ground (I have been involved in developing this approach).

- AHCA: The leading national organization pushing for developmert of an insurance approach has been AHCA. For the past two years, key members have been exchanging information and interacting with the players cited in this section. Last September, the AHCA Journal featured a series on developing private insurance. In addition to stimulating attention to the need for broadening coverage for long term care in general, AHCA has also devoted attention to partial coverage for special requirements, e.g., head injury, spinal cord injury.

- Market: In response to an inquiry from ICP, many of the firms cited as offering coverage suggest they will expand their marketing during the current year. For instance, the Equitable plan mentioned above has been adopted by this policy. Thus, we can assume that inspite of the HIAA report, the market is responding to the growth potential.

(5) Stimulating New Approaches:

Overcoming the market failures identified above will require tremendous momentum in the developing of a long term care insurance offering. AHCA has made a tremendous investment in stimulating the development of private financing. This effort should continue with attention to raising the public's awareness of the need for long term care insurance. As a first step in providing this leadership, a special Task Force on Long Term Care should be appointed to coordinate staff, membership and state affiliate activities with developing the private insurance market. We should anticipate a significant demand upon our technical resources to provide information educating the public to the need for long term care insurance and we should expect that our advocacy network will be called upon to provide the lobbying power to stimulate appropriate legislative and regulatory responses.

Among the tasks which need to be undertaken are the following:

- Public awareness: There is a tremendous public information effort needed to raise the consciousness of the public at large to the changes which longer life will make to society at large. Emperical studies indicate a longer actuarial lifespan for older persons than self-perceived. There is a widespread public stereotyping of the elderly which does not relate to the age 75+ population. There appears to be a significant problem among the elderly and the professionals working in the aging enterprise to accept risky and frail behaviors as parts of the normal aging process. Beyond our continued efforts stimulating the Administration on Aging and the National Institute on Aging to focus on the full spectrum of needs of an aging population, we might wish to encourage the health promotion and health financing agencies of the Federal government to be more aggressive in educating the public. Likewise, we might encourage the AD Council to devote public service announcements to expanding public awareness.

- Documentation and data: Our homes are the laboratories for developing insurance policies. There is a great need for the nursing home industry to parallel the hospital industry in developing baseline data. Simple data, such as the number of persons entering as private pay and converting to Medicaid, is not readily available. AHCA can encourage homes to work with researchers exploring the development of insurance. We can use data collected from our members in informing both the public and research communities to the realities of the market. We can disseminate data which has been collected from other sources to expand general knowledge about long term care.

- Working with insurance companies: While AHCA has initiated some liaison with the private sector and it has worked with SRI and HIAA, there is need for additional direct approach with the market. Just letting them know that we exist and that we are willing to help with technical support in their endeavors would be a first step. Certainly, there may be a role for the Service Corporation in developing specific plan specifications and soliciting companies to bid to provide an expanded role in the market. AARP initially entered the market with Colonial Penn in a very limited offering. Over time, the relationship served both the carrier and the association.

- Working with state Medicaid programs and consumer groups: The crisis of funding for Medicaid has created a favorable environment for providers, consumers and payors to stimulate the private market. AHCA should encourage its state affiliates to approach both Medicaid officials and representatives of consumer organizations to initiate a dialogue on the issues. One idea which moves us toward the objective of broadened coverage would be to have the state government sanction a committee of providers, consumers and state officials to stimulate market development. AHCA should place the issue of private insurance on its agenda for liaison with the Medicaid State Directors and in our cooperative initiatives with consumer groups.

- Stimulating state legislative activities: just as above, the AHCA state affiliates are a powerful tool to leverage market change. Legislative panels could be encouraged to look at prohibitions in the current state regulatory structure which are disincentives to coverage of custodial and intermediate care. Restrictions on indemnity policies and reserve limitations serve as major disincentives. The other area which needs to be considered is the dovetailing of the Medicaid program into the private insurance coverage, i.e., beginning the process of having the private sector as primary coverage rather than secondary. Among the actions which need to be taken are steps to overcome the problems of pre-existing conditions limitations, premium supports and coverage for those unable to meet the medical screens.

- Effecting public sector incentives encouraging the purchase of long term care insurance: public expenditures for long term care may be appreciably reduced if positive incentives were offered to stimulate greater private market coverage. The ideas generated by the AHCA Payment Committee reccmmending specific taxation policy changes (a) to alter the gross income requirements for dependent care, (b) to modify the dependency test, (c) to remove the disincentives for older persons to use their individual retirement accounts (IRA's) and (d) to stimulate reverse annuity mortgages unlocking homeowner equity need to be advanced. Moreover, AHCA must lobby to ensure that pending changes in the federal Internal Revenue Code proposing to place a ceiling on insurance protection for health care be structured so as not to inhibit the development of a long term care insurance market.

- Enticing the public sector to act as reinsurance for private initiative: one of the significant breakthroughs might be to stimulate a private-public partnership with the government acting as a reinsurance agent to absorb some of the market risks. Such an effort would help to overcome the diseconomies of moral hazzard and adverse selection, while keeping the private sector as an available option. A reinsurance strategy encourages the private sector to expand into the market knowing that government will assume some of the risks and it will help to bail them out if the risks are too great.

- Enticing the private sector to act as a reinsurance mechanism: in conjunction with the above approach, for certain service approaches, e.g., continuing care retirement communities, the private market might accept the risks of providing reinsurance especially if there as taxation incentives to move in that direction. CCRC's market to a private pay market and they have actuarially designed approaches to meet future costs. Specific proposals for reinsurance have been discussed in the private sector. Reinsurance frees capital and helps meet reserve requirements. Such an approach could lead to market rated bonds for CCRC development if structured correctly.

LL:cjw
8433.04
January 31, 1984

Table 1. Long-Term Care Insurance Examples
Policy Features of Insurance Companies

	Insurance Company		
olicy Features	Fireman's Fund American Life Insurance Company	Massachusetts Indemnity and Life Insurance Company	Equitable Life and Casualty Insurance Company
killed care covered	Yes	Yes	Yes
ntermediate care overed	Yes	Yes	Yes
Custodial care covered	Yes	No	Yes
ome care covered	Yes	No	Yes
Indemnity enefit	Yes, choice of up to $60 per day for nursing home, $30 per day for home care.	Yes, $50 per day for skilled care or $40 per day for intermediate care.	Yes, choice of up to $60 per day for skilled care, $30 per day for intermediate care, $15 per day for custodial care, and $7.50 per day for home care.
aiting/Elimination eductible period	Choice offered - 20 or 100 days.	60 days	Choice offered - 0, 20, or 100 days.
Length of coverage	4 years for any nursing home confinement, 180 days for for home health.	$75,000 lifetime maximum benefit allows 4.1 years of skilled care or 5.1 years of intermediate care.	24 months for skilled care, 12 months for intermediate care, 6 months for custodial care, and 30 days for home confinement with a $90,000 lifetime maximum benefit.
ales screened or health status	Yes, general questions asked about institutional and physician care in previous months and ability to perform daily activities.	Yes, but limits evaluation to those hospitalized or in a skilled nursing home in prior 12 months.	Yes, detailed list of condition information requested.
re-existing ondition period	30 days	12 months	6 months for conditions appearing in previous 5 years.
Prior hospitali-ation required	Yes, confinement must begin within 30 days after hospitalization of 3 or more days.	Yes, confinement must begin within 28 days after hospitalization of 3 or more days.	Yes, confinement must begin within 14 days after hospitalization of 3 or more days.
Use must be ecommended and eviewed by hysician	Yes, confinement must be recommended by physician and physical exam can be required at company's expense.	Yes, confinement must be recommended by a physician and must be recertified every 30 days.	No explicit statement, but physical exam can be required at company's expense.
Covers mental and ervous disorders	Yes, if demonstrable organic illness.	Yes, if demonstrable organic disease.	Yes, if demonstrable organic disease.
uaranteed renewable	No, non-renewable statewide.	No, non-renewable on group basis.	Yes
Company can hange premiums	Yes	Yes	Yes

Table 1. (continued)
Policy Features of Insurance Companies

	Insurance Company		
Policy Features	Federated American Life Insurance Company	Kemper Group	Great Republic Life Insurance Company
Skilled care covered	Yes	Yes	Yes
Intermediate care covered	Yes	Yes, but very limited.	Yes, added as optional rider.
Custodial care covered	Yes	Yes, but very limited.	Yes, added as optional rider.
Home care covered	No	Yes, private duty nurse.	Yes, private duty nurse.
Indemnity benefit	Yes, choice of up to $30.	Yes, $20 per day for days 1-100 $40 per day for days 101-1095; $10 per day for less than skilled care; $25 per day for private duty nurse at home.	No, pays actual charge up to $ per day for days 1-100 and $40 for days 101-1095 for skilled care; $25 per day for private duty nurse at home; 10% of act charge up to $40 per day for intermediate or custodial care.
Waiting/Elimination deductible period	20 days	None for skilled nursing home care or private duty nurse.	None for skilled nursing home care or private duty nurse, 90 days for intermediate and/or custodial care benefit.
Length of coverage	4 years	3 years for skilled nursing home care and private duty nurse, 2 years for intermediate or custodial care benefit.	3 years for skilled nursing home care and private duty nurse, 2 years for intermediate or custodial care benefit.
Sales screened for health status	Yes, general questions asked about institutionalization and physician care in previous 12 months and ability to perform daily activities.	Yes, specific questions asked about illnesses and institutionalizations.	Yes, specific questions asked about illnesses and institutionalizations.
Pre-existing condition period	30 days	12 months	1 year for conditions appearing in previous year.
Prior hospitalization required	Yes, confinement must begin within 90 days after hospitalization of 3 or more days.	Yes, confinement must begin with 28 days after hospitalization of 3 or more days non-skilled care must also follow 20 days of covered care in a skilled nursing facility.	Yes, confinement must begin within 28 days after hospitalization of 3 or more days.
Use must be recommended and reviewed by physician	Yes, confinement must be recommended by physician and physical exam can be required at company's expense.	Yes, confinement must be recommended and reviewed by physician.	Yes, confinement must be recommended by physician and physical exam can be required at company's expense.
Covers mental and nervous disorders	Yes, if demonstrable organic disease	No	No
Guaranteed renewable	Yes	Yes	Yes
Company can change premiums	Yes	Yes	Yes

Table 1. (continued)
Policy Features of Insurance Companies

Policy Features	Insurance Company			
	Merchants and Manufacturers Insurance Company	Health Insurance Corporation	United Equitable Insurance Company	Transport Life Insurance Company
Skilled care covered	Yes	Yes	Yes	Yes
Intermediate care covered	Yes	Yes, by rider.	Yes	Unclear
Custodial care covered	Yes	Yes, by rider.	Yes	Yes, but very limited.
Home care covered	Yes, private duty nurse	No	No	No
Indemnity benefit	Yes, up to $40 per day for all nursing home care, up to $50 per day for private duty nurse at home.	Yes, intermediate and custodial care paid at 1/2 of rate chosen for skilled care.	Yes, choice of up to $40 for skilled care benefit, 1/2 chosen rate for intermediate or custodial benefit.	Yes, choice of up to $60 per day for skilled care, and up to $15 per day for custodial care.
Waiting/Elimination deductible period	None	None	Choice offered - 0, 20, or 100 days; intermediate or custodial benefit must follow at least 20 days in skilled nursing care.	None for individual policy, 0 or 100 days for group policy.
Length of coverage	4 years for skilled nursing home and home health benefit, 2 years for intermediate or custodial care.	1 year for care in a skilled nursing facility; care in an intermediate and custodial facility is subject to the amount of skilled care received on a 2 for 1 day basis for up to 730 days.	4 years for skilled care benefit, choice offered of 6 or 12 months coverage for intermediate or custodial care.	3 years for skilled nursing care, 120 days for custodial care. Group policy limits skilled nursing care to 2 years.
Sales screened for health status	Yes, specific questions asked about illnesses and institutionalizations.	No	Yes, asks for detailed information about institutional care in previous 6 months and illness and activity restrictions.	Yes, specific questions asked about illnesses and institutionalizations.
Pre-existing condition period	6 months	12 months	180 days	6 months for conditions appearing in previous 12 months.
Prior hospitalization required	Yes, confinement or home care must begin within 14 days after hospitalization of 3 or more days.	Yes, confinement must begin within 30 days after hospitalization of 3 or more days.	Yes, confinement must begin within 30 days after hospitalization of 3 or more days.	Yes, confinement must begin within 90 days after hospitalization of 3 or more days.
Use must be recommended and reviewed by physician	Yes, physician must certify at least once a month that beneficiary needs no greater or lesser care.	Yes, confinement must be recommended by physician and physical exam can be required at company's expense.	Yes, confinement must be recommended by physician and physical exam can be required at company's expense.	Yes, confinement must be medically necessary.
Covers mental and nervous disorders	No	No	Yes, if demonstrable organic disease	No
Guaranteed renewable	Yes	No, non-renewable statewide	Yes	Yes
Company can change premiums	Yes	Yes	Yes	Yes

Table 1. (continued)
Policy Features of Insurance Companies

Policy Features	Insurance Company National Foundation Life Insurance Company	 Mutual Protective/Medico Life Insurance Company	 Columbia Life Insurance Company
Skilled care covered	Yes	Yes	Yes
Intermediate care covered	Yes	Yes, but very limited.	Yes
Custodial care covered	Yes, but very limited.	Yes, but very limited.	Yes
Home care covered	Yes, separate policy and very limited.	Yes, but very limited.	No
Indemnity benefit	Yes, choice of $20-$50.	Yes, 2 plans, $6-12 for days 1-20, $20-30 for days 21-100, $40-60 for 101st day to 4 yrs., for skilled care; $10-20 for intermediate care; $5-10 for custodial care; $5-10 for home care.	Yes, choice of up to $50 per day.
Waiting/Elimination deductible period	None	None	Choice offered - 0, 20, 60, or 100 days.
Length of coverage	3 years for skilled and intermediate care, 90 days for custodial care.	4 years for skilled care, 180 days for intermediate care, 180 days for custodial care, 30 days for home care.	5 years for skilled care, 6 or 12 months for intermediate or custodial care.
Sales screened for health status	Yes, specific questions asked about illnesses and institutionalizations.	Yes, specific questions asked about illnesses and institutionalizations.	Yes, specific questions asked about illnesses and institutionalizations.
Pre-existing condition period	For persons 64 and over, 6 months (2 years for other ages) for condition appearing in previous 5 years.	6 months for conditions appearing in previous 5 years.	6 months for conditions appearing in previous 5 years, plus some conditions specifically excluded.
Prior hospitalization required	Yes, confinement must begin within 14 days after hospitalization of 3 or more days.	Yes, confinement must begin within 14 days after a hospitalization of 3 or more days.	Yes, confinement must begin within 14 days after hospitalization of 3 or more days.
Use must be recommended and reviewed by physician	No specific statement.	Yes, confinement must be recommended by a physician and for skilled care physician must certify once a month that care is needed and received.	Yes, physician must certify that patient needs no greater or lesser care and physical exam can be required at company's expense.
Covers mental and nervous disorders	Yes, if demonstrable organic disease.	Yes, if demonstrable organic condition.	No
Guaranteed renewable	Yes	No, non-renewable statewide.	No, non-renewable statewide.
Company can change premiums	Yes	Yes	Yes

Table 1, (continued)
Policy Features of Insurance Companies

Policy Features	Insurance Company Blue Cross of North Dakota	Blue Cross of Southern California - UltraCare	United Auto Workers
Skilled care covered	Yes	Yes, but limited to Medicare gaps.	Yes
Intermediate care covered	Yes	No	Yes
Custodial care covered	No	No	No
Home care covered	No	Yes	Yes
Indemnity benefit	Yes, choice of $50 per day.	No	None
Waiting/Elimination deductible period	100 days.	No	Direct trade-off of nursing home days (2 for 1) and home visits (3 for 1) with hospital days.
Length of coverage	Choice offered of Nursing 2-5 years.	Nursing home benefit covers days 20-100, home health benefits as needed.	No
Sales screened for health status	Yes, specific questions asked about illnesses and institutionalizations.	No	No
Pre-existing condition period	180 days.	No	No
Prior hospitalization required	No	Yes, for nursing home, no for home health.	No
Use must be recommended and reviewed by physician	Yes	Yes	No, specific statement.
Covers mental and nervous disorders	Yes	Yes	Yes, but only up to 90 days.
Guaranteed renewable	No	No	As long as employed.
Company can change premiums	Yes	Yes	Not applicable, employee benefit.

TABLE 2

LONG TERM CARE INSURANCE POLICY BENEFITS

	Skilled Nursing Care		Custodial, Intermediate Care		Home Health Care	
	Benefits	Conditions	Benefits	Conditions	Benefits	Conditions
United Equitable	$20-50/day for 4 years	After 3 day hospital stay, care must be received in SNF which could meet Medicare standards and which has 24 hour nursing service under supervision of RN. Patient must receive skilled nursing care (using professional nursing methods and procedures) on a daily basis	$10-25/day for 6-12 months	Only after SNF stay of 20 days or more in SNF or licensed ICF or custodial nursing facility, under supervision of RN or LPN	None	
Kemper	$10-20/day for 100 days; $20-40/day for 101st - 1,095th days	After 3 day hospital stay; in SNF licensed by state and which has 24 hour nursing service under supervision of RN/LPN	$10/day for 60 days	Only after SNF stay of 20 days or more; in SNF	$12.50-25/day for private nurse for 3 years	Must be house confined. Services must be recommended by physician
Fireman's Fund	$10-50/day for 4 years	After 3 days hospital stay; in SNF which provides continuous (24 hour) skilled nursing care under supervision of R.N. For injuries/illnesses which are not at first primarily custodial, but which may become custodial	$10-50/day for 4 years	Only after SNF stay; in SNF which provides continuous skilled nursing care under supervision of R.N.	50% of SNF/ICF benefit for 180 days	
Pacific Benefits	$30/day for 4 years	Same as Fireman's Fund	$30/day for 4 years	Same as Fireman's Fund	None	

ITEM 3

Long Term Care:
The Challenge to Society

Health Insurance Association of America

1984

Introduction

In 1983, the Health Insurance Association of America (HIAA) completed a comprehensive two-year study of the social and economic impact of the "graying of America" on the nation's long term care resources.

A number of factors prompted this initiative, including the growing aged population, changing family composition and lifestyle, and the escalating cost of public and private health care programs.

Above all, the HIAA recognized that the problem is societal in scope and defies solution by any single institution, public or private. Within this context, pressures are clearly increasing on the private health insurance industry to play a significant role in providing long term care benefits to the public.

Opportunities and challenges in the development and marketing of such programs are fully explored in the Association's study.

The nation's elderly are a rapidly growing segment of the population. Currently, there are just under 26 million Americans aged 65 or older, about one in nine of the general population. By the year 2000, there will be about 34 million older Americans, or one in eight.

Senior citizens comprise 85 percent of nursing home residents. Moreover, the frail elderly, those 80 and older, are increasing at a faster rate than the general aged population. Some 5.1 million older senior citizens are expected to increase to 8 million by the end of the century. The chronic diseases, and accompanying functional disabilities of the aged, imply an increased need for long term care services.

Changes in Family Composition and Lifestyle

At the same time, there have been major changes in family composition and lifestyle. We live in an increasingly mobile society. Far greater numbers of women are entering the work force. Marriages are occurring later with fewer children and more divorces.

If these trends continue, we can anticipate reduced reliance on family support systems and increased reliance on organized long term care modes. This, in turn, spurs heightened concern about the financing of long term care services.

Long Term Care Cost Inflation

Not only has the aging population grown rapidly, but expenditures for long term care have escalated even more dramatically. Stated in current dollars, in 1980, $20.7 billion was spent for nursing home care, double the $10.1 billion in 1975. Government spending in this area, which accounts for more than 50% of the aggregate, also doubled from $5.7 billion to $11.6 billion over the five-year period.

Out-of-pocket expenditures of $8.7 billion in 1980 are also twice the amount spent five years earlier, while insurance expenditures for nursing home care rose from $78 million to nearly $200 million over the same period. With nursing home expenditures estimated to reach $76 billion by 1990, the financing of long term care thus becomes a critical issue.[1]

For the foreseeable future, government will continue to be concerned about escalating program costs at the federal, state, and local levels. At the same time, inflation in nursing home costs, rising at a higher rate than the general economy[2], implies that fewer people will be able to pay for services from their own personal resources.

In such an environment, there is growing public expectation of the availability of long term care products within the private market. The feasibility of private market approaches is already being explored by various groups. For example, the National Center for Health Services Research has conducted a study which is being described as an assessment of the extent of senior citizen demand for insured long term care benefits.

The alternative to private sector involvement in some form may well be complete government control over long term care in the future. Under such a scenario, political exigencies would determine the lifestyle for those needing long term care.

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[1] *Health Care Financing Review*, Health Care Financing Administration, Fall 1980, Winter 1981, September 1982

Working Papers on Long-Term Care, prepared for the 1980 Under-Secretary's Task Force on Long Term Care, Department of Health and Human Services, October 1981

[2] Between 1975 and 1980:

Nursing home expenditures grew 105%
Consumer Price Index grew 53%
Gross National Product grew 69%

Definition of Long Term Care Services

One of the first tasks of the HIAA study was to identify those services which could be included in a long term care insurance plan. An overriding concern was that the availability of long term care coverage would create incentives to place more patients in a nursing home setting and/or raise health care costs. Therefore, a full range of institutional and non-institutional services was considered and the following definition adopted:

"Long Term Care can be defined as a complex and interrelated array of health, health-related, and social services designed to provide preventive, therapeutic, rehabilitative, supportive, and maintenance care for individuals of all ages who have chronic physical and/or mental conditions which impair the individual's ability to function at his or her own optimum levels of mental, physical, and social functioning."

The key factor in long term care is not age, but functional dependency. Such functional dependency is expected to exist for a minimum of three months.

The goal of long term care, whether rendered in an institutional or non-institutional setting (or a combination of both), should be to restore the individual to optimum functional levels. In addition to medical care services, long term care services include:

- *Homemaker Services*—cooking, shopping, laundry, home management;

- *Chore Services*—less frequent tasks related to home maintenance;

- *Social Services*—guidance in social or emotional problems, advice in financial or legal matters, transportation;

- *Health Related Services:*
  1. Nutrition and health education;
  2. Personal Care Services: bathing, toileting, feeding, assistance in walking, exercise, medication;
  3. Occupational Therapy: medically directed activities to promote the restoration of useful functioning;

- *Skilled Services:*
  1. Physical and Speech Therapy: use of physical or chemical agencies and devices to relieve pain, restore functioning, and prevent loss of use of a part of the body;
  2. Skilled Nursing: administration of medicine, changing of catheter and dressing, evaluation of condition;

- *Housing Services*—provision for continued housing allowances for those undergoing extensive in-patient rehabilitation; group or congregate living arrangements, including social care and dining and service facilities. Some of these might be feasible in long term care products. Others may prove a serious problem for the insurance industry.

Critical Assumptions

Following the identification of nursing home services, the HIAA assessed the present and future environment, based upon two assumptions:

1. Status Quo

Currently the government plays a major role in reimbursing for long term care services, particularly through the Medicaid program. It was felt that incentives inherent in Medicaid preclude development of viable private sector options. Medicaid is already viewed by many as a national coverage program for long term nursing home care, used by far more than the low income population usually thought of as Medicaid's primary clients.

The individual's ability to plan for the transfer of assets expands the number of persons eligible for long term care benefits under the program. Public programs are viewed as a "safety net", a protection against the catastrophic costs of care. Therefore, the HIAA concluded that significant change in public policy in this area is necessary if market initiatives are to be expanded.

2. Reduced Medicaid Involvement

The potential for health insurance type products becoming more widely available might be increased if Medicaid was to become viewed as a less viable option by middle income individuals. Such an occurrence could result as an adjunct to government actions to reduce expenditures by: 1) establishing more stringent eligibility criteria; 2) reducing the type, quantity, and/or quality of covered services; and 3) regulation against and/or greater control over divestment of assets.

In this environment, demand could be stimulated for private long term care coverage by senior citizens, families who want to purchase protection for elderly parents, and younger persons looking to future needs.

Statement of Principles

The HIAA, accordingly, has developed a set of principles for the financing and delivery of long term care services. These principles are:

1. Payment for long term care services should encompass an appropriate mix of public and private funds.
2. Public policies should stimulate private sector involvement in long term care.
3. Public programs and private insurance should provide effective protection against those costs of long term care services they are designed to cover.
4. Every effort should be made to restore physically and mentally impaired persons to their optimal level of functioning.
5. Maintenance of independent living in a community setting should be encouraged where feasible.
6. Long term care should be available in a range of settings, levels of care, and organizational structures to be responsive to the needs of the public.
7. Family and social support services should be utilized to the greatest possible extent, with appropriate incentives for such support.

Major Factors for Consideration

In examining the potential role of the private health insurance industry, the HIAA addressed the various problems of developing, administering, and marketing long term care products.

The Assessment of Needs

The older person often has multiple physical problems, sometimes accompanied by some level of mental impairment. Frequently, the need for assistance in daily activities, such as eating, dressing, walking, and local travel, is more pressing than medical care.

Thus, the assessment of whether an individual requires institutional care and the level and type of care that is needed often involves subjective criteria. In many instances, the patient progresses from need for highly skilled health professional services to lower levels of custodial care as the aging process continues.

Since need, and therefore eligibility for benefits, is not static, health insurance programs should be flexible, reflecting the dynamics of a long term care situation.

Custodial vs. Medical Care

Custodial care is often necessary as a result of physical or mental disability or other deterioration resulting from the aging process. Insurers have long recognized the critical link between custodial care and medical care, and have had considerable difficulty defining eligible services under Major Medical and other benefit plans to deal with the "gray areas" linking the two categories of care.

To remain financially sound requires that insurers generally limit benefits to medical care, with custodial care covered only where necessary to help individuals achieve an optimal level of functioning.

Definition of Provider Roles/Types of Care

Health care provider roles have to be more clearly defined for appropriate placement and determination of eligibility for benefits. For example, nursing homes perform a variety of functions, from housing and social support for the frail elderly to the monitoring of complex medical conditions. There is a need to clearly delineate their functions and whom they should serve.

Also needed is a more precise definition of the various types of care, including skilled, intermediate, day care, home health and hospice care.

Adverse Selection

Adverse selection, from an insurance perspective, occurs when premiums cannot cover claims, because too many of the policyholders are of higher than average risk. A fundamental principle of insurance is that adverse selection must be controlled if financing of an insurance plan is to be actuarially sound. The problem is particularly difficult when considering long term care benefits.

Individuals have thus far shown little evidence of acknowledging the risk of chronic disability. Neither have they demonstrated willingness to plan for financial protection against the cost of long term care services. Therefore, it can be anticipated that the market for long term care products without significant change in public awareness may be concentrated in high risk segments of the population.

To minimize this problem, health insurers believe it is necessary to educate the potential population in need of long term care services of the risk they face. Even with such heightened awareness, insurers will probably need to emphasize individual underwriting, pre-existing condition clauses, upper age limits on eligibility, and the development of long term care benefit plans attractive to younger age groups in order to produce actuarially sound products.

Induced Demand

As with any new product, long term care coverage, if widely sold, will create demand far in excess of what is currently experienced. The accelerating growth in the nursing home industry during the 1970's was, in large measure, due to the expansion of public programs that finance long term care. The impact of private sector participation is expected to accelerate pressures on utilization.

Furthermore, there is a strong possibility of efforts by family, friends, and charitable institutions to obtain reimbursement for care previously rendered free of charge. The induced demand for home care services may well be even more serious than induced demand for institutional care.

Ways to limit induced demand need to be found. Potential mechanisms have already been cited, ranging from stringent medical necessity language and uniform definitions of types of care to plan design features and claims review specifically designed to ease the problem. In addition, insurers would probably expect insured individuals to share a portion of the cost of needed care.

Premium Pricing

Pricing difficulties abound in the area of long term care. Benefits may be paid out years after premium levels are set. Setting premium rates, therefore, has to reflect dynamic risks, such as changes in the cost of care, consumer tastes, consumer incomes, and technological advances. Premiums that accurately recognize these risks in addition to the standard risks of age, sex, and health status might be so high as to limit marketability to a small segment of the population.

Among the possible approaches to minimizing risks are: automatic premium and benefit adjustments; additional policy provisions enabling insured individuals to increase their coverage without medical underwriting; and marketing the long term care product to younger age groups.

Regulatory Considerations

The current regulatory environment is not responsive to the variety of benefits required in long term care. For example, in California, home care benefits are deemed to be more akin to disability coverage than to traditional hospital, medical, and surgical expense protection.

In addition, sales to younger age groups may entail prefunding with associated cash accumulation. Thus, cash values would probably have to be considered. This issue is not addressed under current state legislation and regulation governing health insurance.

Clearly, a practical regulatory framework needs to be shaped to accommodate the successful underwriting and marketing of long term care coverage.

Evaluation of Potential Products

The HIAA evaluated a number of potential model long term care products. These models vary by age at issue, method of benefit payment (i.e. fee for service or indemnity), and various premium and benefit options.

After thorough analysis, the HIAA identified several more probable approaches. These approaches would include the following features: meaningful deductibles and/or elimination periods; adhering to reasonable individual underwriting standards and pre-existing condition clauses; carefully defining levels of care and medical necessity; guaranteed renewability of policies, inflation protection, such as automatic premium and benefit adjustments and the right to increase coverage without medical underwriting; providing for periodic recertification of benefit eligibility; and imposing upper age limits on age at issue of policy to reduce adverse selection.

The specific approaches are:

- *Indemnity benefits for long term care services, with premiums beginning prior to and continuing beyond age 65.* This product can be priced under the assumptions cited above. However, its marketability to younger age groups without a cash accumulation feature is questionable.
- *Indemnity benefits for long term care services, with premiums beginning at age 65 or over.* This type of plan is currently being offered on a limited basis.
- *Indemnity benefits combined with a lump sum settlement option, with premiums beginning prior to age 65.* Under this arrangement, it would be possible to expand coverage after age 65.
- *Indemnity benefits combined with a lump sum settlement option, with a single premium after age 65.*
- *Indemnity benefits combined with a lump sum settlement option before age 65 and annuity benefits after 65.* This approach would be geared to younger people interested in both long term care benefits and retirement income protection.
- *Indemnity long term care benefits combined with annuity benefits and single premiums after age 65.* Annuity benefits would begin immediately. Such a plan, however, would require a large premium and, hence, possess limited appeal.

Other Options

Long term care services could be funded through a variety of existing insurance products, such as whole life policies. Non-insurance vehicles could also be explored. Individual Health Accounts, a tax preferred capital accumulation mechanism dedicated to health care, is a concept which has been proposed and deserves further consideration.

Life Care Communities are receiving increased attention as a source of protection for the elderly. In effect, these communities employ insurance principles by spreading the risk of loss equally among all residents. A potential role exists for the health insurance industry to financially underwrite and manage such programs.

Recommendations

Based upon its evaluation, the HIAA recommends the following:

- Exploration of a public-private sector partnership to assure financial protection against the costs of long term care services.
- Public policy initiatives to encourage greater private sector involvement in the delivery and financing of long term care.
- Public policy initiatives to provide positive incentives for private sector experimentation in the financing of long term care services.
- Broader education of the public of their potential long term care needs as an integral part of comprehensive retirement planning.
- Public policy initiatives to encourage individual and family responsibility in this area.
- Continued state responsibility for indigent individuals in need of long term care services.
- The creation of a regulatory environment conducive to the development and marketing of long term care plans.

Conclusion

Financial protection against the costs of long term care may well become the dominant financing issue in the coming decades.

To successfully market programs responsive to this need, long term care coverages must prove attractive to younger individuals. Capital accumulation plans with cash settlement options, and/or the ability to convert to a combination retirement and long term care benefit, may stimulate demand among younger age groups. In any event, a great deal of work remains to be done by private insurance companies to design benefit plans for long term care.

The continued escalation of health care costs remains a concern for acute and long term care services. In large measure, the rapid growth of the nursing home industry in the 1970's was due to the expansion of public programs that finance long term care, producing well-documented strains on government budgets. New private products may fuel yet another round of inflation in long term care costs, threatening the financial integrity of private and public programs.

Finally, changing demographics and budgetary constraints may force a reexamination of the extent of individual and family responsibility to meet long term care needs. Tax incentives and other public measures should be considered to stimulate increased consumer involvement.

Clearly, the health insurance industry stands ready to participate in the public debate and in the resolution of these critical issues.

ITEM 4. LETTER FROM ARTHUR LIFSON, WASHINGTON DC, CHAIRMAN, TASK FORCE ON LONG-TERM CARE INSURANCE, HEALTH INSURANCE ASSOCIATION OF AMERICA, TO SENATOR JOHN HEINZ, CHAIRMAN, SPECIAL COMMITTEE ON AGING, DATED DECEMBER 7, 1984

DEAR SENATOR HEINZ: This letter is in response to the questions posed to the Health Insurance Association of America regarding long-term care coverage at the September 21, 1984, hearing of the Senate Special Committee on Aging.

What do you think is the potential for capitating payments for long-term care?

The potential for providing a comprehensive program of acute and long-term care for the elderly, on a capitated basis, is currently being tested by the social/HMO demonstration projects. Expansion of this model will heavily depend on the experience of these experiments.

Generally, health maintenance organizations offer their enrollees a full range of health care services. This has been one of their major attractions. The HMO setting also allows for flexible case management and creates incentives for providing effective less costly medical care for enrollees. The social/HMO experiments build on the traditional HMO approach to comprehensive care.

Capitation of long-term care services only, however, seriously restricts the possibilities for flexible case management in handling patient needs and will probably have limited appeal for the elderly consumer.

Since it is clear that case and service management will be an important aspect of long-term care insurance do you think that capitation is the way to go?

Case and service management are important aspects of long-term care. However, capitation may not be the only financial arrangement which can accommodate a case management function. Capitated arrangements for preventive, maintenance, and acute care have been around for some time. Yet, there is no concensus that capitation is the "way to go" for all persons, nor that capitation is a viable option for all localities. Given the fact that long-term care insurance is in its infancy, and there is little experience with long-term care coverage on a per capita fee basis, a judgment to opt for a capitated approach is much too premature.

Given that insurance companies are now developing HMO's in order to increase their share of the health insurance market, wouldn't it make sense for the insurers to experiment with expanding HMO services to include long-term care?

The decision to experiment with different products rests with the individual insurance company. The lessons to be learned rom the S/HMO demonstrations may well influence that decision.

The HMO market is predominately focused on the employed population with HMO coverage offered as an option in an employee health benefit package. The addition of a long-term care benefit will increase the costs of the package for business and the enrolled population. This is certainly a consideration for the HMO operator and those who consider managed health care systems as a cost effective alternative to fee for service reimbursement.

In order to spread the risk across larger groups of people, would it be feasible to market long-term care insurance to families with older persons, rather than to elderly persons themselves? Have there been any market tests to evaluate this approach?

I am not aware of any test marketing to families of older persons. The market for long-term care insurance may well include such families as well as the elderly. Another potential target market is the under 65 population. Education as to the risks and costs of long-term care services may heighten awareness of the need to factor long-term care needs into planning for retirement.

I hope that these responses have been helpful.

Sincerely yours,

ARTHUR LIFSON.

Appendix 2

LETTERS AND STATEMENTS FROM INDIVIDUALS AND ORGANIZATIONS

ITEM 1. LETTER FROM ROBERT N. BUTLER, M.D., THE MOUNT SINAI MEDICAL CENTER, NEW YORK, NY, TO SENATOR JOHN HEINZ, DATED OCTOBER 27, 1984

DEAR SENATOR HEINZ: Thank you for the opportunity to contribute my comments to the record of your September 21 hearing on financing chronic illness.

A no man's land exists in the field of private and social insurance. Coverage of long-term care is ignored by Medicare. There is a monumental gap in medi-gap and other private health insurance. Medicaid comes into play after the individual is pauperized. This insurance void stymies the development of the very services that might best help many individuals to live their final years at home.

The public and private sectors are locked into an Alphonse-Gaston Act. Major institutions of government and the private sector fight for second or third place in meeting the long-term care needs of a growing society of elders. Many justifications for footdragging are given.

There are plenty of plausible reasons not to act. Yet, there is an overriding reason for action important to us all: With every passing year, the people of our country have better and better chances of reaching the late seventies and eighties. These are the years when long-term care services are increasingly needed for independent living and survival with dignity.

The costs of procrastinating are clear: Impoverishment, excessive depency, avoidable institutionalization, preventable suffering, and loss of self-esteem in the last years of life for millions of Americans, including our future selves.

All of us have a motive and cure for action. What remains is to make up our minds to act together. The security that seems so elusive to us individually can be made possible through insurance and other forms of cooperation.

We do have ways of filling the void in the fabric of private and social insurance protections. We do not start at zero. We have had experimental and demonstration service projects to indicate how to organize systems of service adapted for long-term care.

We have a good notion of what the major expenses are likely to be. We have the growth of geriatrics, gerontology, professional and semiprofessional training in care of the elderly, development of biomedical and psychosocial sciences oriented to chronic disease and aging, senior citizen organizations, and a variety of volunteer and community services. We have improved the financing of later life through Social Security, pensions, and other arrangements covering many but not all Americans adequately.

We have many elements of a comprehensive system of supports for long-term care. But they are fragmented, unevenly developed, anemically funded, and disorganized.

Other countries have found ways to handle long-term care needs comprehensively. Take Israel as an illustration. In 1980, the Knesset (parliament) approved in principle the addition of long-term care insurance to the Israeli social insurance system. It authorized the development of an implementation plan and the collection of payroll taxes to build up the fund to pay for the needed services. The implementation plan remains to be completed, but work on it is going on.

I mention this not to advocate the addition of long-term care insurance to Medicare, although that is one way to go. There are other possibilities. As a condition of receiving tax privileges of Individual Retirement Accounts and tax-deferred annuities, the Federal Government could require that a portion of the funds be reserved to buy a basic private long-term care insurance policy. The policy, offering a standard set of benefits, would provide for cost and quality controls and administrative safeguards against profiteering.

We could require that all health insurance policies provide long-term care benefits, partially funded by premium savings due to increased deductibles on hospitalization. We could encourage the states to buy private long-term care insurance for individuals eligible for Medicaid.

To minimize dangers facing individual insurance companies in terms of adverse risk selection, we could develop a national reinsurance program. It would give the public certainty that the insurance it buys is durable. Providers of service should be able to count on fair compensation for what they do. A reliable revenue stream would support improvement in scope and quality of service. And, with the resources possible through universal coverage, we could move beyond conventional insurance to develop better means of sustaining the family members on whose shoulders fall the main duties of assisting the disabled day to day in the home.

I don't think there is any impassible financing barrier to the development of a systematic approach to long-term care, if we are bold and imaginative in using the public and private sectors. We must not let insurance considerations dominate the development of balanced services policy. Rather, we must develop such policy backed up by insurance, facilities and manpower development, health services research, and other supports for a durable system.

The time is ripe for producing a realistic vision of what can be done by the public and private sectors. The lack of that vision—a consensus view of goals, means, and responsibilities for proceeding—is the greatest block to progress in long-term care.

A blue-ribbon commission of a dozen outstanding Americans should be formed to provide that vision. After making their own investigations and hearing from the public experts about what needs to be done and possible solutions, the commission would make a report with recommendations for public and private action, aiming for the inauguration of a comprehensive program in 3 to 5 years. The commission would stay alive after its report to promote public debate and the challenge to action.

It is time to get Alphonse and Gaston off center stage.

Sincerely,

ROBERT N. BUTLER, M.D.

ITEM 2. STATEMENT OF LEIGHTON E. CLUFF, M.D., EXECUTIVE VICE PRESIDENT, THE ROBERT WOOD JOHNS FOUNDATION, PRINCETON, NJ

Mr. Chairman, I am Leighton E. Cluff, executive vice president of the Robert Wood Johnson Foundation. I am a physician, who prior to joining the Foundation was a professor of medicine at the Johns Hopkins University and professor and chairman of medicine at the University of Florida College of Medicine. Let me state at the outset that my remarks represent my own views and do not necessarily reflect the Foundation's position.

It is a pleasure to discuss issues of long-term care and insurance for the elderly American population. These matters are of substantial concern to me and to the Foundation, and we have committed considerable time and resources to developing new approaches to them during the past few years.

Let me begin on the very positive note that as a physician, I have witnessed impressive gains, both in medicine and in economic programs, which have greatly improved the life and outlook for older Americans. Their income has risen, primarily from Social Security retirement funds, so that today only one in seven people 65 and over is below the poverty level, compared to one in four back in 1970. Moreover, an impressive 75 percent of those 65 years or older own their own home and of these, 80 percent have their mortgage entirely paid off. I will come back to this fact later, because it may have important implications for alternative financing for long-term care.

Concurrently, Federal health insurance for the elderly has had a profound effect on their health and well-being. We have gone from a pre-Medicare/Medicaid situation where half the elderly had no private health insurance to today's situation where 93 percent have a regular source of medical care and where the large gap between the use of physician services by the poor and nonpoor elderly has been completely eliminated.

This is a striking achievement. With it, however, comes the need for a fundamental shift in insurance from an emphasis primarily on the elderly's acute care needs to one which now includes effective and efficient long-term care, especially for those 75 and older. This may include better utilization of community support services already in place, such as religious and voluntary health organizations, and innovative approaches to financing long-term care insurance or the services themselves. I will elaborate on both of these areas.

A close look at this age group reveals the rationale for the expanded focus. First, those 75 and older are the fastest growing age segment; and fully half of those 75 or older have limitations on their daily activities due to chronic illnesses or disabilities. This group accounts for a large and increasing proportion not only of hospitalizations, hospital days, and physician visits, but also of home health services. For instance, people at 75 use four times as many home health services than do those at 65, yet funding for home services is critically lacking.

Medicare, of course, provides "insurance" for those 65 and over to partially cover acute hospitalization. The prevalence and duration of chronic and disabling conditions in the elderly requires that we do as well or better in providing funding mechanisms for long-term care in appropriate settings, whether they be nursing home or in-home community environments.

The likelihood of being in a nursing home is four times greater for an 85-year-old than it is for a 75-year-old. Today, in fact, about one-quarter of those 85 years or older live in nursing homes, comprising a majority of the 1.5 million nursing home residents. Up to one-half of these residents are afflicted with Alzheimer's disease or related dementias, once considered the natural scourage of "aging," and now recognized as a disease process selectively affecting about 2 to 4 million older people. Nursing homes are likely to remain their best mode of late-stage care until basic science can unravel the cause and/or provide means of preventing or arresting Alzheimer's and related dementias. An additional 3 million elderly living outside nursing homes also require long-term care and 500,000 of these are completely homebound.

Those elderly within nursing homes, and those with chronic conditions requiring long-term care in the Nation's cities, towns, and rural areas, face different kinds of problems. But lack of appropriate long-term care insurance is common to them all. Public and private sector expenditures for health care for the elderly (65 and over) totaled $83.2 billion in 1981; nearly two-thirds of this was spent by the public sector. Moreover, out-of-pocket health expenditures for the elderly are as large today as they were before Medicare and Medicaid. These expenses, which were 20 percent of income in 1965, dipped, but were back to 19 percent of income by 1980. These expenditures, seen in light of existing gaps in long-term care provisions, raise serious questions of whether current programs effectively and efficiently are meeting our national needs in this area.

Medicare's major expenditures occur in the elderly person's last year, and to a lesser extent, next-to-last-year, of life. This is because Medicare primarily pays for hospitalization. Only a tiny fraction of Medicare funds can go toward reimbursement for long-term care in skilled nursing facilities or in-home settings apparently out of a fear that expenditures in this area would have mounted so rapidly as to jeopardize the financial viability of the entire program. The crux of the issue is to ensure that the elderly in need of nursing home facilities can afford them, while simultaneously insuring that those elderly who have impairments, but of a less severe nature, can afford and have available appropriate services within the community. Many of the problems both groups of impaired elderly face may be resolved by devising new approaches to long-term care insurance.

First let us examine problems in financing long-term care in nursing homes. These homes have been the principal means of care for the elderly who are most severely impaired, including a high percentage of persons with Alzhemier's disease. Often there is a long waiting period prior to admission. In the meantime, nursing home candidates often remain in acute care hospitals, an expensive holding facility, until openings in nursing homes occur. These hospital expenses usually are covered by Medicare. Exacerbating these admission delays is the reluctance of many nursing home administrators to admit medically complicated patients because staff lack sufficient numbers of trained nursing personnel to care for them adequately. For instance, only about 5 percent of nursing home employees are licensed health care practitioners—R.N.'s and licensed practical nurses. There is a average of less than two such practitioners to care for every 100 nursing home patients. Therefore, while the Nation is paying more than $36 billion annually for hospital care for the elderly—primarily through Medicare—these funds are not expected solely for unavoidably needed acute care treatment or surgery. Medicare reimbursement policies actually have encouraged long-term hospitalization of chronically ill or disabled elderly for two main reasons. First, Medicare will only pay for nursing home care if it is directly preceded by hospitalization and has a 100-day nursing home limit. This creates a revolving door phenomenon as numerous patients awaiting nursing home admission stay in the hospital until they are placed and return to the hospital once the 100 days are used up. Second, the chronically ill elderly intending the return home may stay in the hospital until recovered enough to care for themselves because the alternative use of in-home services would largely have to be paid for out-of-pocket. The new diagnostic related groups (DRG) reimbursement system may drastically alter this practice in the next few years, although it is unclear what directions the changes will take.

The Nation annually is expending $25 billion for nursing home care. Government programs, primarily Medicaid, pay for about two out of every three of these dollars; therefore Medicaid—not Medicare—has greatly accelerated the rapid expansion of this industry. In fact, nearly 40 percent of all Medicaid funds are allocated to nursing homes, as are one-quarter of the elderly's out-of-pocket health care dollars. An unintended consequence of Medicaid financing is the need for the elderly to "spend down" their assets to the level that qualifies them for a Medicaid-financed nursing-home bed.

The number of elderly residing in nursing homes increased 7 percent between 1963 and 1977, and totals more than a million of our older citizens. This new influx is due to several factors, many of them primarily social and economic rather than medical. Incomes tend to be low: nearly one out of every five persons 72 years lives below the poverty level. This is explained in part because women 75 years and older outnumber men of the same age group by two to one and have only about one-half the income of men. Moreover, women, as opposed to men, tend to live alone: only 20 percent of women over 75 as opposed to 70 percent of men are married and living with a spouse. The higher participation in the labor force by young and middle-aged women—coupled with a higher mother-to-daughter ratio—means there are fewer daughters, who traditionally have cared for their elderly mothers. As a result, nursing homes have been the fastest growing sector in health care. Between 1960 and 1980, the number of nursing home beds skyrocketed 400 percent. Projections are that by 1985 there will be a further 35 percent increase and that is the just the beginning. Within 40 years, the number of beds may total 2.3 million, or a million more than those in the entire hospital sector. Therefore, while the trend in acute care hospitals is toward ambulatory as opposed to institutional care, the opposite is true for the elderly. Is this tremendous shift to nursing home care necessary? I think not. Clearly, nursing homes will continue to be the primary means of late-stage care for victims of Alzheimer's and other severe dementias until biomedical science can discover means for preventing or arresting their effects. But what of the remainder? We need to rethink methods of financing and providing long-term care for the impaired elderly who—from a medical standpoint—could live and function in the community setting with supportive services.

National expenditures for all forms of home health and social services total an estimated $[illegible]1 billion. This represents only one-eighth of national funds presently spent on nursing home care. Despite these expenditures, however, patients and the Nation may not be getting their money's worth from in-home care.

Available services do not address all needs and frequently are fragmented and uncoordinated. In fact, it is often the frustrating inability of patients (or their families) to get appropriate home-care services which lead the elderly to seek or accept premature entry to nursing homes. About a third of nursing home residents could live and function in their previous or specially designed communities with adequate in-home care financing and availability. Instead, unable to piece together and pay for various community-based services into a cohesive long-term care regimen, frustrated families often opt for nursing home solutions. Home care has become professionalized. It is costly. It is uncoordinated and fragmented, involving more than 140 Federal and State programs. Problems may be as simple as finding transportation to and from the physician's office—taxis are too expensive for many—or as complicated as arranging for intermittent nursing and homemaking services. Long-term care organizations are overloaded financially and organizationally. Often they employ nurses and homemakers on a full-time basis, so that full-time charges can help pay overhead costs. Yet often the elderly are neither able to afford nor do they desire a full-time attendant. Simply stated, too often services are not provided in a way which makes sense for the user. Moreover, such services are financially out of reach for a large segment, particuarly the retired middle-class elderly.

Some in-home services are covered by Medicare, or—for those qualifying—by Medicaid. They may also be covered under title XX of the Social Security Act, which provides Federal block grants to States for a broad range of social services, but eligibility is confined to the poor, as defined by the States. Or they may be funded by the Older Americans Act of 1965 and its subsequent amendments which created a national/State/local service network for the elderly, generally defined as those over 60. Despite these autonomous programs, in-home services too often fall into funding cracks.

Medicare's main support is for hospitalization, not long-term care services. Medicaid is available only to the destitute and desperately elderly. These programs leave the middle-class elderly in need of long-term care in a financial bind. While the average Medicaid-funded yearly cost of nursing homes is about $30,000, the out-of-pocket cost for home services is only about one-half to two-thirds that amount. Many middle-income elderly's assets are tied up in their private homes, leaving them no readily available source of cash for long-term health insurance simply does not now exist to any appreciable degree; less than 1 percent of the total national nursing home bill, for instance, was covered by private insurance in 1981. The Robert Wood Johnson Foundation, in conjunction with five other foundations, is supporting a national study to examine, systematically, means for improving the financing and organization of long-term care for the health impaired elderly. The study is being conducted by the Brookings Institution, and directed by economist Alice Rivlin, formerly Director of the Congressional Budget Office and now a senior fellow at Brookings. It is anticipated that this study, which is to be completed in May 1986, will provide some new directions to many of the issues raised during your hearing. But this is not enough.

The committee's concern and commitment to exploring long-term care insurance approaches should be a tremendous impetus for catalyzing efforts by the public and private sectors to create sorely needed means to improve this situation. Let me now provide some suggestions on areas which would benefit from such efforts. We need:

Continued, vigorous Federal support for basic biomedical research on Alzheimer's disease and related dementias. Recent scientific reports elucidating biochemical and anatomic changes in specific regions of the brains in persons who have died with Alzheimer's disease provide encouraging indications that this effort will pay off. Indeed it could essentially dissolve a major cause of human suffering and nursing home confinement among the elderly. New methods for enabling nursing home staff to better assist Alzheimer's patients. The Foundation, for example, is helping university schools of nursing to establish affiliations with nursing homes in an effort to improve the nursing care provided. The Federal Government through the National Institute of Child Health and Human Development is sponsoring a program to establish similar linkages between nursing homes and medical schools. New methods of improving patient functional status which may enable confined elderly without Alzheimer's disease to return to independent living, an area which has received little attention from the medical, nursing, and rehabilitation professions.

New alternatives to nursing homes for these and other disabled elderly so they can live in settings such as "life care" or continuing care retirement communities. These independent institutions without walls—many of them church-sponsored—provide middle-class elderly people with a full range of medical, social, and living arrangement services. For instance, the Robert Wood Johnson Foundation and Commonwealth Fund gathered actuarial data which better defines financial and legal obligations of existing types of special care communities. We now need to encourage their implementation.

Improved access, availability, and coordination of formal and informal community support systems and appropriate means for providing long-term care to our rural elderly. For instance, the Foundation is funding a program on a "swing-bed" concept of rural hospitals, whereby these hospitals use acute care beds for chronic patients when appropriate. Additionally, the Foundation is supporting a program on interfaith caregivers to see whether coalitions of churches and synagogues can help to fill the current gap in providing means for informal community long-term care. Further exploration of alternative means of financing insurance or services, such as "home equity conversions."

I would like to expand on these last two points for a moment. We have only begun to tap available in-home care community resources. Community, religious, and other volunteer groups are a natural resource for providing support and assistance to the elderly disabled in their communities. We live in changing times, with changing social values and structures. We have an increased prevalence of chronic disease to be sure. We also have an increased incidence of divorce, of separation, and of widespread dispersion of families. Much of the basic support ordinarily provided by the family has begun to erode. Even intact families, however, cannot provide all long-term care needs. Diverse community organizations have begun to emerge to close some of the gaps, including national voluntary health organizations focused on specific diseases, university programs in which students assist elderly community residents, and voluntary home health care groups which provide meals, housekeeping, or transportation. We need to make better use of their services and encourage more such efforts.

In addition, religious organizations—churches and synagogues—which exist in virtually every community, have traditionally contributed to human support and are well equipped to do so. These groups can provide direct services such as meals-on-wheels and could also assume a mediating role between other formal care providers and those elderly who are disabled and in need of such care. With the proliferation of Federal, State, and regional programs, however, religious congregations have failed to fully recognize or develop their potential to provide personal support services unavailable through these more formal, often fragmented programs. Additionally, there has been a great resistance to establishing interfaith, ecumenical programs. Parochialism has hampered cooperative efforts, even among neighboring churches of the same denomination. The Robert Wood Johnson Foundation, through grants, is encouraging ecumenical coalitions of churches and synagogues to develop systematic means of helping the elderly and disabled at risk of institutionalization to remain in their homes. This area deserves more of our attention.

We also have failed to explore fully use of home equity conversions to provide an alternative financing source for new long-term care insurance or for the services themselves. Although the concept of "reverse mortgages" is not new, it is only now being applied to securing protection against the high cost of long-term care. Results of two recent Foundation-supported studies have confirmed that home equity conversion represents a promising alternative worthy of further consideration. However, the two proposed mechanisms each have elicited some opposition. Reverse annuity mortgages, which provide an annual income stream (annuity), and may guarantee lifetime tenancy for the owner, have met with resistance from potential lenders. This is primarily because under this mechanism, the lending institution provides an annuity to elderly home owners until their death (or until they sell their home), and then is paid back by receiving title to the house or cash from its sale. This requires startup capital and means a negative cash flow for several years. Since the principal plus interest on the loan are not repaid until the borrower dies or sells the home, risks are considered to be open ended, and return on investment is not considered to be competitive with other investment opportunities. These opportunity costs have loomed as a barrier to investor participation in such programs. At least one Wall Street brokerage firm, however, has developed a reverse mortgage plan which is attempting to make up for an anticipated 10-year negative cash flow; this lender will receive payment covering the loan's principle, plus interest compounding at 11 percent, plus a percentage share of the home's appreciated value.

Conversely, the sale/leaseback arrangement has met opposition from consumers. Although under this arrangement the institution similarly provides annuity and lifetime tenancy, title to the house is transferred to the lending institution immediately. Consumers do not want to give up title now simply to purchase another insurance policy. Many have worked a lifetime to own their house free and clear, and are reluctant to transfer the title at a time when so many other changes in their life are taking place. Clearly more work, such as the brokerage house plan mentioned above, needs to be done in this areas to find a fit between the concerns of lenders and those of consumers.

From this discussion, I hope it is evident that the country needs a systematic, coordinated, integrated approach to long-term care needs of the elderly and to developing means for financing them. It is possible, for instance, that a public financial program will be required for many of our elderly citizens. As our population increasingly grows older, the children of the old are themselves old and retired. This means that neither the elderly parents nor their elderly children will have much additional income. In addition to developing home equity conversion, we might explore whether public and/or private long-term care insurance can be generated early in life, enabling people to build up reserves over a long period. Additionally, we have only recently begun to look at joint public-private programs which may be an important contributor to successful long-term care and insurance programs.

Meeting the increasing needs of our people for more and better long-term care services, and the means to pay for these services, is a real and present national challenge of enormous economic as well as health import. I appreciate being asked to submit this statement and am delighted the committee is exploring means for meeting this challenge.

ITEM 3. LETTER FROM FRANK M. FORMAN, PRESIDENT AND CHIEF EXECUTIVE OFFICER, FORMAN & ASSOCIATES, INC., BELLEVUE, WA, TO SENATOR JOHN HEINZ, DATED OCTOBER 1, 1984

DEAR SENATOR HEINZ: I would like to include the following testimony in your recent hearing, "The Cost of Care for the Chronically Ill: The Case for Insurance."

First, let me thank you for your interest in, and support of, the long-term care needs of our elderly. I am pleased to learn of your hearings and would like to share our firm's experience with you. We are a resource that you may wish to explore as your hearings evolve.

Forman & Associates, Inc. is the pioneer and leader in the long-term care insurance field. We committed our resources in 1979 to servicing the long-term care needs of the elderly. We have had a long relationship with an Illinois insurance company and have assisted them in writing over 60,000 policies. They have grown from 300 to 5,000 agents, and from $3 million to $33 million in premiums since our joining them.

The first generation of long-term care policies, which we were instrumental in designing and introducing to the marketplace, proved the viability of the market. However, they had limitations. The second generation of policies is now coming off the drawing board. I have just returned from New York and Hartford, Conn., where my associate, Mitchell Hart and I negotiated with the giants in the insurance industry. As a result of these meetings, we now have a firm commitment from a $10 billion insurance group that they will enter this market in a big way. Until this breakthrough, the market has been served by only a few small companies.

I can tell you our strategy in bringing the major carriers to the marketplace. First, an insurance plan must be responsive to the realistic needs of the elderly. Second, the product must be of such quality that groups and associations of the elderly will support the plan. Third, the highly vocal critics of insurance companies and their dealings with the elderly must see the value and impeccability of the new products and offer little criticism.

In addition to the above marketing considerations, the elderly hold firmly to two critically mistaken ideas that must be addressed. They believe they already have long-term coverage with Medicare and Medicare supplement plans. They do not believe they will be institutionalized for a long period of time. In order to overcome these widely held, erroneous ideas, we have determined some specific strategies. It will require companies of impeccable credentials to enter the marketplace and the major associations will need to endorse the product in order to overcome the above misconceptions. It will require credible voices to reshape these ideas. I recently encouraged a government agency to consider helping to educate the public as to the actual length of nursing home stays and the coverage that is available.

We propose that the new product, the second generation of policies, offer indemnity coverage with no prejudice as to the level of care—skilled, intermediate or custodial. We recommend a 5-year benefit plan that would be guaranteed renewable and have few limitations and exclusions. Home care with a transition allowance, when the patient leaves the nursing home and returns home, will be included by those companies we are now encouraging to enter the market.

The task for all—government, nursing home associations, and organizations of the elderly—is the task of education. The need to carry the message needs to be recognized and strategies implemented by government and the health care industries.

Once again, let me thank you for your support of the elderly. I wish you great success in your efforts on their behalf.

Sincerely,

FRANK M. FORMAN.

ITEM 4. LETTER FROM SHELDON L. GOLDBERG, EXECUTIVE VICE PRESIDENT, AMERICAN ASSOCIATION OF HOMES FOR THE AGING, WASHINGTON, DC, TO SENATOR JOHN HEINZ, DATED OCTOBER 25, 1984

DEAR MR. CHAIRMAN: The American Association of Homes for the Aging is pleased to have this opportunity to convey its views on "The Cost of Caring for the Chronically Ill: The Case for Insurance." We commend the Senate Aging Committee for its interest in and commitment to seeking innovative solutions for addressing the long-term care needs of this nation's aging population.

AAHA is the national organization representing over 2,300 nonprofit homes, housing and health-related facilities for the aging. AAHA member homes have deep roots in the communities they serve through sponsorship by religious, fraternal, labor, private, and governmental organizations. While there is diversity among our member homes, they all have two things in common: they are all operated on a nonprofit basis as a service to the community in which each is located, and they are all committed to delivering the best possible services and care to each of the approximately 500,000 persons they serve annually.

Providers, today's and tomorrow's elderly, the disabled, insurers, and public policy decisionmakers are all faced with long-term care challenges of immense proportions. The sheer demographics of aging makes the issue of assuring accessible, affordable long-term care critical. Even at the present time, we are not coming close to adequately meeting the long-term care needs of our older population (65-plus) which totals 26 million and comprises 11.4 percent of the population. Unless action is taken in the near term to address this unmet need, the problem may overwhelm us in the not so distant future; in 2030, 59 million Americans will be 65 or older, representing 18 percent of the population.

There is an urgent need to develop long-term care financing mechanisms. Attention is also needed on developing and providing the entire range of care and services. These long-care needs demand the participation and contribution of numerous sectors in this society, public and private alike.

AAHA strongly believes that the concept of long-term care insurance holds significant promise as one means for easing what is currently the catastrophic expense of the elderly—long-term care costs for chronic and custodial care service needs.

However, AAHA believes just as strongly that long-term care insurance is not, and will never be, the panacea for this critical problem of financing long-term care. Therefore, before addressing the "case for insurance," the Association must emphasize its belief that long-term care insurance should not be considered a substitute for coverage provided under public programs, particularly Medicaid and Medicare. Attention to the insurance approach must not divert needed attention from efforts to protect existing programs and to seek improvements in long-term care coverage under these and even new programs.

In this context, then AAHA is keenly interested and involved in the development of a multiplicity of long-term care insurance options and innovations.

One approach, of course, is the traditional individual or group insurance policy which would cover specified long-term care services. The well-known Medicare supplemental (medi-gap) insurance policy model reflects this approach. AAHA is supportive of efforts to develop this type of insurance, provided that such an offering actually represents an option for securing protection against the costs of long-term care—usually the result of chronic and custodial conditions, not acute or subacute episodes of illness.

It is understandable that insurers want to move cautiously into this relatively new insurance market, as experience and data tend to be insufficient to determine risk. However, we would urge that this cautious approach not result in a long-term care insurance policy of such a restrictive nature—such as one employing excessive utilization controls—as to render it meaningless. Therefore, AAHA recognizes that some industry "safeguards" against high risk probably will need to be included, such as an elimination period and a finite coverage period. However, we would encourage insurers, at a minimum, to refrain from including the most acute-care oriented control mechanisms such as the 3-day prior hospitalization requirement.

In addition, AAHA urges that the necessary steps, such as adequate consumer education, be taken in order to create a clear understanding and broad market acceptance of the offerings. Without laying this groundwork, the cost of marketing including commission structures could threaten the viability of the policy.

Because progress in the development of long-term care insurance is needed "yesterday," and because public and private coverage of long-term care services are intricately connected, AAHA is convinced that the Federal Government has a role to play in the development of this initiative. At the very least, the Federal Government could take the lead in desperately needed data collection relative to utilization and cost of long-term care services. In addition, the government should actively participate in consumer education efforts. Education regarding benefits covered and not covered by such programs as Medicare and Medicaid would help older persons make informed decisions about their health and long-term care coverage needs.

Similarly, the State as the traditional regulator of insurance has an important role to play in establishing and maintaining consumer protections in the sale of long-term care insurance. At the same time, however, this State regulatory mechanism needs to be sensitive to the changing insurance needs of the aging population and retain flexibility in setting standards for this relatively new type of coverage.

The long-term care insurance concept also is strongly evident in a variety of service delivery/insurance combination settings; the health maintenance organization (HMO) model is illustrative of this.

AAHA has been very supportive of efforts to expand the HMO model to include coverage of long-term care services. Known as the social/HMO, the Association is pleased that Congress was instrumental in effecting implementation of the "S/HMO" demonstration project—an exemplary public-private partnership in long-term care innovation. The data and experience derived from this demonstration project undoubtedly will contribute greatly to the policy, program, and financing formulation for long-term care. The life care/continuing care setting also offers a specialized opportunity to address the long-term care needs of the elderly.

While these service delivery/insurance models currently are able to serve only a limited number of people, AAHA is convinced that this approach holds special promise for the future of providing and insuring long-term care. The Association is currently focusing in this sphere in its efforts to find ways to make these options more widely available. AAHA looks forward to sharing its findings with the Committee as progress is made on this most pressing issue.

Again, as one important means for improving the financing and provision of long-term care to our Nation's elderly, AAHA is committed to the development of long-term care insurance options. The Association stands ready to work with the Senate committee and the Congress in the pursuit of this mutual goal, as well as improvements in existing programs of importance to the elderly.

Sincerely,

Sheldon L. Goldberg.

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